Commonwealth of Kentucky
Public Employee Health Insurance Program
Third Annual Report

Prepared for:

Commonwealth of Kentucky
Governor
General Assembly
And
Chief Justice of the Supreme Court

October 1, 2003

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Executive Summary

Scope and Process

In accordance with the provisions of KRS 18A.226(5)(b), enacted by the 2000 General Assembly as a part of Senate Bill 288, this document comprises the third annual report from the Kentucky Group Health Insurance Board to the Governor, the General Assembly, and the Chief Justice of the Supreme Court. It includes:

- A review of the recommendations put forth by the Board in its October 2002 report.
- Summary experience for the Commonwealth's Public Employee Health Insurance Program during calendar year 2002.
- An analysis of how choice impacts the Public Employee Health Insurance Program and the Commonwealth's health insurance costs.
- Comparisons of the Commonwealth's Public Employee Health Insurance Program to the insurance provisions of those of other state government employers and private employers.
- An evaluation of self-funding and issues the Commonwealth should consider in determining whether to change its funding approach.
- Summary information with respect to the healthcare flexible spending accounts funded by the Commonwealth for active employees who waive health insurance through the Public Employee Health Insurance Program.
- Information regarding Public Employee Health Insurance Program governance and administrative issues.
- Summaries of legislated health insurance benefit mandates and mandates passed by the 2002 and 2003 General Assemblies that affect the Public Employee Health Insurance Program.

To prepare this report, research was conducted by the Office of Public Employee Health Insurance and Mercer Human Resource Consulting and presented to the Board at its monthly meetings. Based on these presentations and the Board's articulated recommendations, the report was drafted by Mercer Human Resource Consulting on behalf of the Board and modified to incorporate the Board's comments.

Please refer to the *Glossary* at the end of the report for definitions of terms used in the body of the report.

2003 Board Recommendations

Following a thorough review of the Commonwealth's Public Employee Health Insurance Program, the Kentucky Group Health Insurance Board makes the recommendations outlined in this section. These recommendations are presented in three primary categories:

- Health benefit provisions,
- Program governance, and
- Program administration.

The rationale for the recommendations in each of these sections is summarized briefly prior to the recommendations. Detailed findings from the comprehensive analysis conducted by the Board, upon which these recommendations are based, are provided in the individual sections of this report. These findings are summarized in the final section of this report, under Conclusions.

Health Benefit Provisions

With the changes other employers made to their health plans from 2000 to 2002, overall, with the exception of its dependent health insurance contributions, the Commonwealth's 2002 health insurance program was more generous than the median of the large employer market nationally and state government employers. Given anticipated changes in 2003 and 2004, based on employers' responses to recent surveys, in 2004, it is expected that the provisions in the Commonwealth's Option A health offerings will be even further above average when compared to those of large, national employers and state government employers. However, the Board feels it is important for the Commonwealth to view its health insurance benefits in the context of its total compensation program. In this context, the Board generally believes that the Commonwealth's health benefit plan provisions must be above the median of the market to attract and retain qualified employees. Consistent with this belief, the Board, with supporting input from the Employee Advisory Committee, supports the Commonwealth's historical policy of paying the full cost of single health insurance under a health option with attractive benefit provisions.

Public Employee Health Insurance Program members' 2002 dependent health insurance premium contributions were 2 to 3 times the market average for large, national employers and state government employers. The magnitude of these contributions has contributed to a continual decline in the percentage of Public Employee Health Insurance Program members enrolling their dependents in the Commonwealth's program. To counter this trend and make dependent health insurance coverage more affordable, the Board recommends that the Commonwealth subsidize the cost of dependent health insurance premiums, to the extent financially feasible. However, neither the Board or the Employee Advisory Committee support this action if it comes at the expense of discontinuing the Commonwealth's policy of paying the full cost of single coverage in the lowest cost A option available in each county.

In summary, the Board recommends, that the Commonwealth:

- Maintain the policy of providing single lowest cost Option A coverage to employees with no employee contribution.
- Maintain attractive provisions within the Commonwealth's health benefit options, to enhance the Commonwealth's ability to attract and retain qualified employees.
- To make health insurance coverage more affordable for employees' dependents, subsidize the cost of dependent health insurance premiums, to the extent financially feasible while maintaining no employee contribution for single coverage in the lowest cost Option A.

Program Governance

The percentage of Public Employee Health Insurance members that retirees and their covered dependents comprise grew from 14.3% in 1999 to 19% by the end of the first quarter of 2003. Due to the impact of age on individuals' health care costs, as illustrated in Exhibit VII, this trend has significant cost implications for the Commonwealth's Public Employee Health Insurance Program. In fact, in 2002, the average allowed expenses (total covered health expenses incurred by members before applying their co-payments) for retirees and their covered dependents were 84% higher than those of active employees and their dependents. This impact is exacerbated by the entities whose retirees participate in the Commonwealth's program whose active employees do not – municipalities and other local governmental bodies and regional universities that participate in a state-sponsored retirement plan. As indicated in the Board's October 2002 report and supported by an independent analysis conducted by The Segal Company at the request of the Interim Joint Committee on State Government, these "unescorted" retirees added between $14 and $16 million in excess claims to the Public Employee Health Insurance Program in 2001.

Members of the Public Employee Health Insurance Program generally select the option available to them that maximizes the benefit they receive (minimizing their total out-of-pocket expenses), thereby increasing the cost of the program. Similarly, if entities are allowed to choose whether to insure their employees under the program or not, a major factor in each entity's decision will be whether it can obtain lower costs by doing so. Unfortunately, since health insurance premiums are based on the health insurance claims of the group being covered, generally, if an entity's cost would be lower under the Commonwealth's program, the average health care expenses of the entity's members will be higher than the average health expenses of Commonwealth group members overall. This premise is supported by the fact that the 2002 average allowed charges of members of the Public Employee Health Insurance Program employed by quasi/local governmental bodies were 8% higher than the average for all other active employees. Therefore, to the extent possible, it is important for the Public Employee Health Insurance Program to limit, or eliminate, the ability for entities to enter or exit the program or choose just to insure segments of their employee/retiree population.

Additionally, the policies applied by the various entities that participate in the Commonwealth's Public Employee Health Insurance Program can negatively impact the cost of the program. If an entity allows its employees to enroll in or discontinue coverage without restriction, some employees will only elect coverage when they know they will have expenses, thereby selecting

against the plan and increasing the program's costs for all members. Indicative of this type of selection, the 2002 average allowed charges of COBRA beneficiaries were 26% higher than the average of the entire group covered under the Public Employee Health Insurance Program. Furthermore, there are specific requirements in Internal Revenue Code laws and regulations that must be met for employee benefits, including pre-tax contributions for health insurance coverage, to maintain their tax-favored status.

Finally, there are inconsistent plans and policies that currently apply to the funds the Commonwealth contributes for those individuals who are eligible to participate in the Public Employee Health Insurance Program, but who waive health insurance. These inconsistencies can be difficult to explain to employees who believe that they participate in the same "program", and can lead to arrangements that may not comply with Internal Revenue Code laws and regulations.

In summary, to protect the financial integrity of the Public Employee Health Insurance Program and ensure compliance with applicable Internal Revenue Code laws and regulations pertaining to tax-favored employee health benefits, the Board recommends that the Commonwealth:

- Require the active employees of all entities whose retirees participate in the Commonwealth's Public Employee Health Insurance Program to also participate.

  or

  Require entities whose retirees participate in the Commonwealth's Public Employee Health Insurance Program and whose active employees do not to be responsible for the actuarial difference in cost of their retirees.
- Require any entity whose active employees currently participate in the Public Employee Health Insurance Program to continue to provide health insurance to all its active employees through the Public Employee Health Insurance Program as long as the entity continues to participate in a state-sponsored retirement system.
- Statutorily require all entities that participate in the Public Employee Health Insurance Program to abide by the administrative rules set forth by the Office of Public Employee Health Insurance or require each of these entities to contractually agree to abide by these rules, in accordance with IRS guidelines.
- Require any entity that accepts funding from the Commonwealth for health insurance and funds any amount to a flexible spending account for individuals that waive health insurance through the Commonwealth to abide by the flexible spending account rules set forth by the Office of Public Employee Health Insurance, which follow IRS guidelines.

Program Administration

While the Commonwealth could gain programmatic advantages by self-funding the Public Employee Health Insurance Program, including the potential to offer the same health insurance options, at the same cost, to all its members statewide, there are also several downsides to self-funding. Although self-funding often has the potential to lower overall health care costs by lowering risk charges and other fixed expenses, in 2002 the Commonwealth's health insurance costs were lower under its insured arrangement than they would have been had the Commonwealth self-funded its program. This assumes that the Commonwealth's claims costs would have been the same had the Commonwealth been self-funded. Results of the 2003 health insurance bidding process indicate that the Commonwealth's 2003 health insurance costs would be 6% to 15% higher, if the Public Employee Health Insurance Program were self-funded rather than insured under its current arrangement. The 2001 incurred claims for the Public Employee Health Insurance Program, as reported by the Commonwealth's health insurance carriers, were projected forward to 2003 assuming 14% health insurance cost trend per year and added to the administrative fees and specific stop-loss premiums quoted by the qualified self-funded bidder to arrive at the program's projected 2003 self-funded cost. Neither the 2002 nor 2003 cost differential takes into account the additional cost to the Commonwealth for the expanded administrative requirements it would assume under a self-funded arrangement.

Some state governments and some private employers have formed cooperatives for the purpose of purchasing prescription drugs, to obtain better pricing arrangements as well as enhanced utilization management services. Participation in a pharmacy benefit purchasing cooperative could lower the Commonwealth's prescription drug costs by 3% to 10% and provide more consistent pharmacy benefit administration (formularies, step-therapy, quantity limits, etc.) to members of the Public Employee Health Insurance Program. However, from a practical perspective, participation in a pharmacy benefit purchasing cooperative will **only** be an option for the Commonwealth if it decides to self-fund its health insurance benefits at some point in the future.

To encourage insurance carriers to provide good quality service to Public Employee Health Insurance Program members, OPEHI, and its benefit coordinators, the Commonwealth has incorporated performance guarantees in its health insurance contracts, with monetary penalties if performance standards are not met. OPEHI receives periodic reports from each of the Commonwealth's health insurance carriers outlining their performance in relation to the performance guarantees to which they agreed and holds meetings and conference calls with the insurance carriers, as necessary, for continuous quality improvement. However, the Commonwealth's ability to monitor the performance of its insurance carriers and recommend revisions to improve performance over time could be enhanced if on-site performance reviews were conducted by OPEHI, or an independent third party, periodically to verify carriers' reported performance results.

To attempt to ensure that the health insurance offerings that are made available to members of the Public Employee Health Insurance Program provide adequate access to a reasonable number of healthcare providers at in-network benefit levels, the Commonwealth has specified minimum network requirements in its Request for Proposals for the Public Employee Health Insurance

Program. Based on feedback from members of the group and legislators, over time, the Office of Public Employee Health Insurance has modified these requirements. While the health plans providing insurance to the Public Employee Health Insurance Program experience difficulties in keeping their physician provider directories current and there is no accurate, comprehensive database available of all physicians practicing in a given county within the Commonwealth, the Board feels that it is important for the program to continue to specify minimum provider network requirements.

Therefore, the Board recommends that the Commonwealth:

- Self-fund the Public Employee Health Insurance Program if:
  - the projected cost savings to the Commonwealth over time could potentially offset the risk the Commonwealth would assume, and
  - it would enable the Commonwealth to offer the same health insurance options at the same cost statewide.
- If the Commonwealth decides to self-fund its health insurance program, investigate the impact of joining a purchasing pool for pharmacy benefit management.
- As part of continuous quality improvement, conduct on-site reviews to validate performance results reported by the Commonwealth's Public Employee Health Insurance Program insurance carriers and/or third party administrators.
- If health insurance contracts are awarded based on a county by county evaluation and selection, maintain the following network requirements in determining whether health insurance bidders are qualified to offer coverage to members of the Public Employee Health Insurance Program in a given county:
  - A bidder must have at least one county hospital in its network, if one or more hospitals exist in the county and any bidder for that county has at least one county hospital in its network.
  - A bidder's physician network for the county must include at least 25% of the largest number of primary care physicians reported by any bidder for that county.
  - In counties where at least one bidder reports 10 or more specialists in its network, a bidder's physician network must include at least 40% of the largest number of specialist physicians reported for that county by any bidder.

Background and History

The *Health Insurance Market for Employees and Retirees of Kentucky State Government – Research Report No. 286*, dated August 12, 1999, prepared by the Program Review & Investigations Committee Staff, provides the following historical information regarding the Commonwealth's Public Employee Health Insurance Program.

> *The Commonwealth first contributed funds for the health insurance premiums of its employees in 1972. From that time until the mid 1980's, Blue Cross & Blue Shield was the only insurance carrier offered to the state group. After experimenting with two HMO plans in 1981 and 1983, the Personnel Cabinet made more than a dozen additional plans, mostly HMOs, available to employees in 1984. Still, the indemnity plan offered by Blue Cross & Blue Shield was the dominant plan chosen. Of the 90,000 employees eligible for state-provided insurance in 1987, 64,000, or 71 percent, were enrolled in the Blue Cross & Blue Shield Key Care indemnity plan.*
>
> *In September 1987, Blue Cross & Blue Shield notified state officials of its intention to cancel the Key Care plan on October 15, 1987. This led to a decision by state policymakers to self-fund the healthcare program under the name Kentucky Kare.*
>
> *Note: The Commonwealth first contributed funds for the health insurance premiums of teachers in 1972. However, the Commonwealth began contributing funds for the health insurance premiums of other state employees prior to 1972.*

As part of extensive changes to health insurance laws adopted in HB 250, the 1994 General Assembly established the Kentucky Health Purchasing Alliance (Health Purchasing Alliance), which became effective for Commonwealth Group members effective July 1, 1995. Under the Health Purchasing Alliance, from mid 1995 through 1998, Commonwealth Group members had a choice of five Kentucky Kare options. Additionally, Commonwealth Group members could also choose one of four HMO options, four POS options, or five PPO options all through several insurance carriers.

Due to mounting losses under Kentucky Kare as a result of adverse selection from diminishing enrollment, the 1998 General Assembly enacted House Bill 315, which dissolved the Health Purchasing Alliance effective December 31, 1998. This led to the Commonwealth re-establishing an independent healthcare program, the Commonwealth Public Employee Health Insurance Program, for Commonwealth Group members.

Public Employee Health Insurance Revisions 1999 to 2004

In 1999, the Public Employee Health Insurance Program offered two HMO options (A and B), two POS options (A and B) and two PPO options (A and B) through insured arrangements with seven insurance carriers (Advantage Care, Aetna, Anthem, Bluegrass Family Health, CHA Health, Humana, and Pacificare). Two indemnity plan options were offered to out-of-state retirees through Anthem. These options were continued in 2000, with the following primary revisions:

- An EPO Option C was added to provide an option to Commonwealth Group members with a lower employee premium contribution.
- Aetna was discontinued due to its elimination in the 2000 RFP process.
- A feature was added to all 2000 options that reduced the prescription drug co-payments members had to pay after they had paid 50 co-payments in a year for themselves and covered family members.
- Coverage of outpatient mental health/chemical dependency services was expanded
  - from 30 to 45 visits annually in the A options and
  - from 21 to 36 visits annually in the B options.
- Out-of-state retirees were allowed to elect any POS or PPO option offered by any of the insurance carriers insuring Commonwealth Group members, as no insurance carrier was willing to insure an indemnity plan for these individuals.
- The Commonwealth revised its contribution policy to provide a contribution that was at least equal to the Single premium rate for the lowest cost Option A in every county.

In 2001:

- The insurance carriers offering health insurance coverage to members of the Public Employee Health Insurance Program changed as follows:
  - Aetna was re-introduced as a healthcare option for the Commonwealth Group in twenty-eight counties within the Commonwealth.
  - Anthem expanded its PPO service area for Commonwealth Group members by fourteen counties.
  - Advantage Care ceased to exist.
  - Pacificare stopped offering health insurance to anyone in Kentucky.
  - Bluegrass Family Health expanded its service area for Commonwealth Group members by nine counties.
  - CHA withdrew its HMO and POS options from twenty-three counties. However it newly introduced PPO options in four eastern counties where it previously offered HMO and POS options.
  - Humana discontinued its KPPA HMO for Commonwealth Group members.
- The following changes in benefit provisions were made:
  - Prescription drug co-payments in the PPO B option were reduced. For generic drugs, the member's co-payment decreased from $15 to $10, for brand name drugs from $20 to $15 and for non-formulary drugs from $40 to $30.
  - Members' cost-sharing for diagnostic testing, in a setting other than a physician's office, was changed from 20% co-insurance after the annual deductible was met to a $10 co-payment per visit in the PPO A option.

- Inpatient day and out-patient visit limits applicable to mental health and substance abuse services were eliminated from all of the Commonwealth Group's health insurance options, in accordance with House Bill 268, which was enacted by the 2000 General Assembly.
- Coverage of amino acid preparations and low-protein modified food products was added to all of the Commonwealth Group's health insurance options pursuant to House Bill 202, which was passed by the 2000 General Assembly.

In 2002:

- In response to requests from Legislators and members of the Commonwealth's Public Employee Health Insurance Program, the Commonwealth implemented two new requirements as a condition for a health plan to be offered in a county:
  - If one or more hospitals exists in the county and any bidder has at least one of the county's hospitals in its network, every other bidder must have at least one county hospital in its network to be qualified to be offered.
  - The health plan's network must have at least 25% of the largest number of physicians in any bidder's network for that county in order to be qualified to be offered.
- To lessen the potential impact of adverse selection, the Commonwealth stipulated that a health plan's B option premium rates must be at least 5% lower, but no more than 10% lower than the A option premium rates for the same plan type (HMO, POS or PPO) and coverage level (Single, Parent Plus, Couple, Family).
- The following changes in carrier offerings occurred:
  - Like 2001, Anthem expanded its PPO service area for Commonwealth Group members by fourteen counties.
  - Aetna was discontinued as an offering for Commonwealth Group members in eleven counties.
  - While Bluegrass Family Health's HMO and POS options were newly offered in five counties, these options were discontinued in three counties. Bluegrass Family Health's PPO option was no longer available in one county where it was available in 2001. However, this option was newly introduced in eight countries.
  - CHA's HMO and POS options were discontinued in fourteen counties and newly added in thirteen counties. Its PPO options were added in four counties, but discontinued in the four counties where offered in 2001, due to provider contracting difficulties.
  - Humana's HMO and POS options were no longer available in three counties where offered in 2001 and its PPO options were discontinued in ten counties.

In 2003:

- Again, in response to requests from Legislators and members of the Public Employee Health Insurance Program, the Commonwealth tightened the network requirements applicable to 2003 bids:
  - The 2002 RFP hospital requirement was continued.

- However, to be qualified to be offered in a county in 2003, a health plan had to:
  - have network primary care physicians of at least 25% of the largest number reported by any health plan bidding that plan type in the county and
  - if any bidder had more than five specialists in a county, a health plan must have had network specialist physicians of at least 40% of the largest number reported by any health plan bidding that plan type in the county.

- Aetna did not respond to the Commonwealth's RFP, as it was not willing to continue to provide health insurance to members of the Commonwealth's Public Employee Health Insurance Program. This affected eighteen counties and about 8,500 employees/retirees.
- Anthem withdrew from fifty counties, affecting around 15,600 employees and retirees.
- Bluegrass Family Health extended coverage to eight additional counties. However, due to either the Commonwealth's more stringent network requirements or termination of some providers' contracts, Bluegrass Family Health wasn't an option in six counties in 2003 where it was available in 2002.
- While CHA did not extend its service area to include more Commonwealth counties in its 2003 bid, it did extend its HMO and POS options to 6 additional counties and its PPO option to 46 additional counties. However, it failed to meet the Commonwealth's 2003 network requirements in two counties where it was available in 2002.
- Humana extended coverage (PPO only) to 2 additional Western Kentucky counties for 2003. However, due to its failure to meet the Commonwealth's 2003 network requirements, Humana wasn't an option in 2003 in fourteen counties where it was available in 2002.
- The following benefit revisions became effective:
  - coverage of dental services was limited to care required as a result of an accidental injury and anesthesia and hospital services that are medically required to safely provide dental care for children below the age of nine and persons with serious mental or physical conditions,
  - coverage of routine vision care was eliminated, and
  - a mail order pharmacy feature was implemented to allow members to receive a 3-month supply of maintenance prescription drugs for a 2-month co-payment.

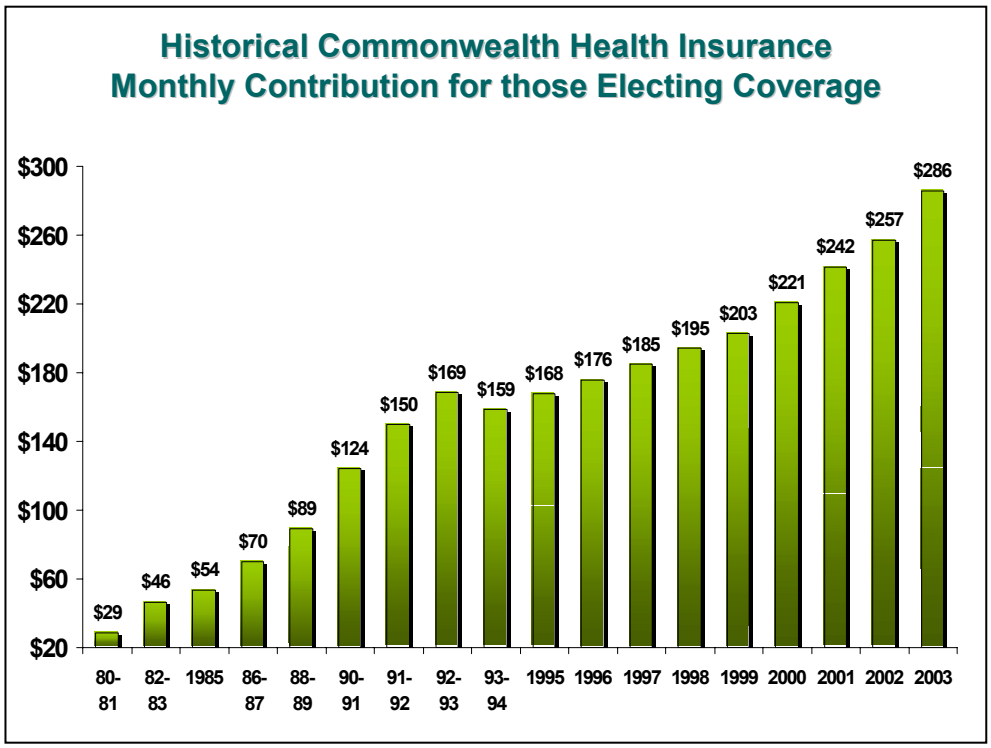
For 2004:

- The 2003 RFP hospital requirement was continued.
- However, the physician network requirements were modified, such that the specialist physician network requirement only had to be met in counties where at least one bidder reported ten or more specialists, rather than in counties with five or more specialists as applied in 2003.
- The point at which members' prescription drug co-payments are reduced will be increased from 50 co-payments per year for a member and all his/her covered family members combined to 75.

Historical Per Capita Commonwealth Health Insurance Contribution

From $9.75 per covered employee in 1972, the Commonwealth's contribution for employee health insurance grew to an expected average of $286 in 2003. The Commonwealth's per employee contribution from the 1980-1981 plan year through 2003 is reflected in Exhibit I.

Exhibit I

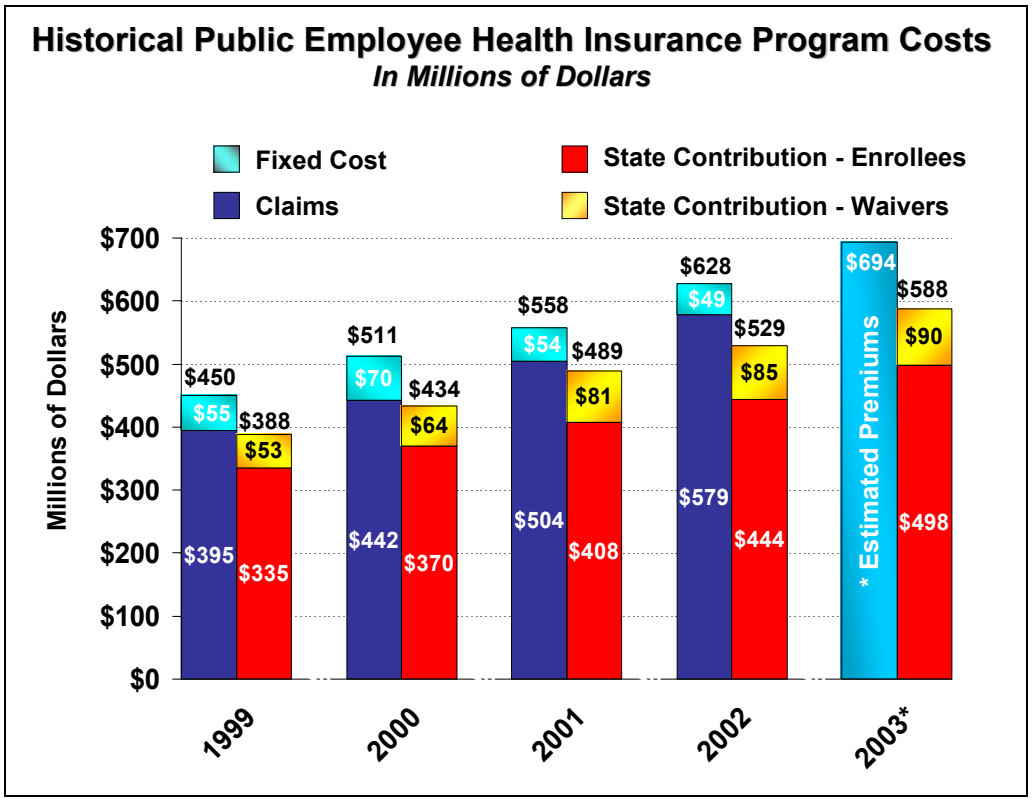


Source: Personnel Cabinet

Public Employee Health Insurance Program Aggregate Costs 1999 to 2003

The total dollars in health insurance premiums (from both employer and member contributions) remitted to the insurers covering members of the Public Employee Health Insurance Program in 1999 through 2003 (estimated) are reflected by the blue bars in Exhibit II. The portion of these dollars actually paid by the Commonwealth's health insurers to healthcare providers for services received by members of the Public Employee Health Insurance Program comprise the dark-blue section of these bars, while the lighter-blue section of each bar reflects the amounts retained by the Commonwealth's insurers for administrative expenses, risk charges and profit. (The actual amounts paid to healthcare providers for services received by members of the Public Health Insurance Program are not yet available for 2003. Therefore, the blue bar shown for 2003 reflects estimated premiums to be paid to the Commonwealth's health insurance carriers.)

Exhibit II



Source: Claims reported by the Commonwealth's insurers and compiled by MedStat and enrollment reported by the Commonwealth.

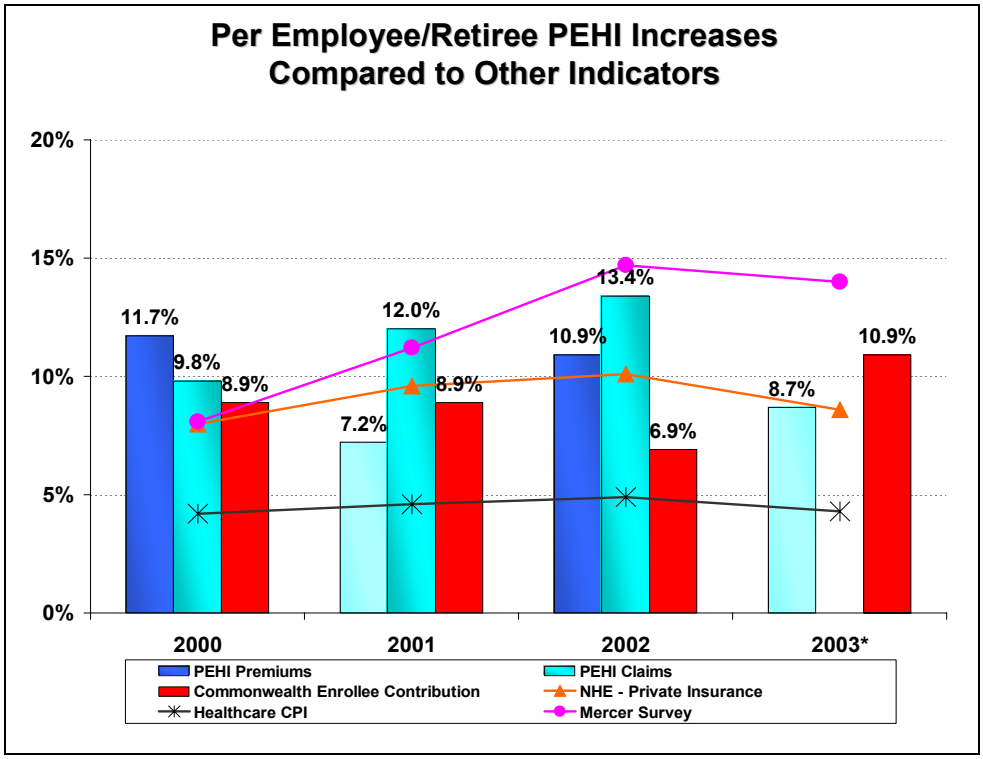
Also reflected in Exhibit II are the amounts the Commonwealth expended in 1999 through 2003 for all members of the Public Employee Health Insurance Program. These expenditures are reflected by the orange bars. The darker section of each bar reflects the amounts contributed by the Commonwealth for those individuals who elected health insurance through the Commonwealth. The lighter section at the top of each bar reflects the Commonwealth's healthcare flexible spending account contribution for eligible individuals who waived health insurance through the Public Employee Health Insurance Program. (Please note that the amounts shown as the Commonwealth's contribution include the portion of Public Employee Health Insurance Program premiums paid by all of the employers and retirement systems of individuals eligible to participate in the Public Employee Health Insurance Program. Additionally, the contribution to the healthcare flexible spending accounts of individuals who waived health insurance includes any forfeitures from these accounts.)

Public Employee Health Insurance Program per Employee/Retiree Cost Increases

For comparison, the per employee/retiree increases in: total premiums for the Public Employee Health Insurance Program from 2000 through 2003 (PEHI Premiums in the chart), total payments to healthcare providers for members of the Public Employee Health Insurance Program (PEHI Claims in the chart), and the Commonwealth's contribution for those enrolling in health insurance (Commonwealth Enrollee Contribution in the chart) are charted in Exhibit III in contrast to the corresponding increases:

- in National Health Care Expenditures for Private Insurance as reported by the Centers for Medicare & Medicaid Services, Office of the Actuary; released in January 2003, based on 2001 data (NHE – Private Insurance in the chart),
- the medical component of the Consumer Price Index (Healthcare CPI in the chart), and
- the percentage increase in employee health insurance costs reported by employers who responded to an annual survey conducted by Mercer Human Resource Consulting (Mercer Survey in the chart).

Exhibit III



Sources: Claims reported by the Commonwealth's insurers and compiled by MedStat and enrollment reported by the Commonwealth were used to develop PEHI Premiums, PEHI Claims and Commonwealth Enrollee Contribution.

U.S. Department of Labor, Bureau of Labor Statistics for Healthcare CPI

Office of the Actuary at the Centers for Medicare & Medicaid Services for NHE Private Insurance

Mercer Human Resource Consulting for Mercer Survey

2002 Board Recommendations Accomplished

The Board put forth many recommendations in its 2002 report. The following briefly summarizes the 2002 recommendations that have been acted upon.

Recommendation	Resolution
Pay full cost of single lowest cost Option A.	Policy still in effect.
Restrict funds appropriated by the Commonwealth for employee/retiree health insurance to use for employee/retiree healthcare benefits. Therefore, consistent with KRS 18A.225(2)(g), recoup forfeitures from the healthcare flexible spending accounts funded by the Commonwealth, for those who waive health insurance, from all entities that participate in the Commonwealth Group and return these to the Commonwealth's Public Employee Health Insurance Program, to the extent permissible by federal standards.	Policy in effect.
Consistent with the goal of the Commonwealth's retiree health insurance program to attract and retain career employees: ▪ The eligibility and state contribution provisions of the existing retiree health insurance program should be maintained for current employees and retirees. ▪ For new employees, the length of service required to be eligible to participate in the retiree health insurance program should be lengthened from 5 to 10 years. However, the Commonwealth's current contribution structure should be retained for individuals in this group with ten or more years of service.	HB 430, which was enacted by the 2003 General Assembly, lengthened the years of service required of individuals who participate in SPRS, CERS and KERS to be eligible to participate in the Commonwealth's retiree health insurance program from 5 to 10 years for individuals hired on or after July 1, 2003. No change was made in the Commonwealth's contribution structure for individuals in these groups with ten or more years of service.

Commonwealth Public Employee Health Insurance Program
2002 Experience

This section of the report provides a summary of the trends identified from 2000, 2001, and 2002 claims and enrollment data submitted by the insurance carriers that provide health insurance coverage to individuals who participate in the Commonwealth's Public Employee Health Insurance Program, as compiled by MedStat.

Restatement of 2001 Experience

Please note that claims for 2001 have been restated from the 2002 report to reflect the actual claims incurred in 2001 that were not paid until 2002. In the 2002 report, these claims were estimated. Additionally:

- A separate group was established, Quasi/Local Government, to segment the enrollment and claims experience of active employees of municipalities, cities and other local governmental bodies that participate in the Public Employee Health Insurance Program from the State Employees group where these individuals were included in the past.
- MedStat reclassified the brand name drugs consumed by members of the Commonwealth's Public Employee Health Program, affecting the breakdown of these prescriptions between single and multi-source brand name drugs.

A Note About 2002 Experience

Reimbursements due to Commonwealth Group members who qualified for a reduction in prescription drug co-payments because they, in combination with covered family members, filled more than 50 prescriptions in 2002, are reflected in the 2002 prescription drug costs included in this report. However, claims for medical services and supplies received by Commonwealth Group members in 2002 that were not paid as of March 31, 2003 have been estimated to be 2% of the 2002 medical claims paid through March 31, 2003.

2002 Trends

Key measures for the Commonwealth's 2002 plan year, in comparison to the 2001 year, are provided in Exhibit IV.

Exhibit IV

	Public Employee Health Insurance Program 2000, 2001 and 2002 Experience				
	2000	2001	% Change	2002	% Change
Medical Claims	$355,304,194	$399,320,673	12.4%	$455,907,012	14.2%
Rx Claims	$86,411,348	$104,247,320	20.6%	$123,237,364	18.2%
Total Claims	$441,715,543	$503,567,993	14.0%	$579,144,376	15.0%
Premiums Paid	$511,369,510	$558,002,180	9.1%	$627,662,326	12.5%
Covered Lives	225,850	225,623	(0.1%)	225,622	0.0%
Per Covered Life					
Medical Claims	$131.10	$147.49	12.5%	$168.39	14.2%
Rx Claims	$ 31.88	$ 38.50	20.8%	$ 45.52	18.2%
Total Claims	$162.98	$185.99	14.1%	$213.91	15.0%
Premiums Paid	$188.68	$206.10	9.2%	$231.83	12.5%
Loss Ratio[1]	86.4%	90.2%		92.3%	

Source: Claims and enrollment reported by the Commonwealth's insurers and compiled by OPEHI and MedStat.

In aggregate, the Commonwealth's health insurance carriers issued payments to medical providers, other than pharmacies, of roughly $456 million for services received in calendar year 2002 by Commonwealth Group members. This represents an aggregate increase of 14.2% over calendar year 2001. This followed a 12.4% increase from 2000 to 2001.

Higher than marketplace trends, payments for prescription drugs in the Commonwealth's program increased by 18.2%, in aggregate, from $104.2 million in 2001 to $123.2 million in 2002. This followed a 20.6% increase from 2000 to 2001. In comparison, participants in Mercer's *National Survey of Employer-Sponsored Health Plans* reported aggregate prescription drug cost increases of:

- 16.9% nationally for employers in all industry groups with 500 or more employees (17.8% in 2001),
- 15.5% for state government employers (18.2% in 2001), and
- 16.6% for employers located in the South (U.S. census region) with 500 or more employees (17.9% in 2001).

Note: The increases reported by survey respondents reflect the net increase in cost after taking into account the increases in prescription drug cost sharing implemented by some survey respondents. There were no increases in members' prescription drug cost sharing in the Commonwealth's program. In fact, prescription drug co-payments in the Commonwealth's PPO B option were reduced in 2001 to make them consistent with the Commonwealth's other B options.

[1] *Total Claims divided by Premiums Paid*

Because prescription drug expenditures increased at a much higher rate than other healthcare expenses, pharmacy service expenditures grew as a percentage of the Commonwealth's total healthcare expenditures from 19.6% in 2000 to 20.7% in 2001 and 21.3% in 2002. In 1999, prescription drugs comprised 18.1% of Commonwealth Group members' healthcare claims.

Total healthcare claims increased in aggregate by 15% from 2001 to 2002. This followed an increase of 14% from 2000 to 2001. In 2002, these expenditures totaled a little over $579 million. In 1999, health insurance claims totaled only a little less than $395 million.

While claim payments to medical providers form the majority of a health plan's expenditures, every health plan, whether insured or self-insured, incurs operational expenses for claims payment, network management, care management and associated services. As the Commonwealth has insured all of its health options since 1999, total expenditures by the Commonwealth and participating Commonwealth Group individuals to purchase health insurance are reflected in the premiums paid to the insurance carriers bearing the risk for the program. In calendar year 2001, these premium payments totaled roughly $558 million. This reflected an increase from 2000 of 9.1%. In calendar year 2002, these premium payments totaled roughly $628 million, an increase from 2001 of 12.5%. In 2002, like 2001, payments for medical supplies and services received by Commonwealth Group members increased at a faster pace than premiums paid to the Commonwealth's insurance carriers. Therefore, the loss ratio (incurred claims divided by premiums) increased from 86.4% in 2000 to 90.2% in 2001 and 92.3% in 2002. While 13.6% of premiums were retained by the Commonwealth's health insurance carriers in 2000 for operating expenses and profit, this decreased to 9.8% of premiums in 2001, and 7.7% in 2002. The 1999 loss ratio was 88.4%, 11.6% of premiums were retained by the Commonwealth's health insurance carriers in 1999.

While the figures provided above reflect changes in aggregate expenditures year over year, it is also important to consider changes in the number of covered lives. The number of employees/retirees insured under the Commonwealth's health insurance program increased roughly 1.5% in 2002. However, like 2001, due to a decline in individuals electing Family coverage (coverage for the employee/retiree, a spouse and one or more children), the total number of covered lives insured under the Commonwealth's program remained relatively constant. Although the number of covered spouses declined slightly year over year, in essence, the increase in the number of employees/retirees covered was offset by a decline in the number of children covered. As the average claims cost for a child covered under the Commonwealth's program is roughly 37% of that of an employee/retiree, part of the Commonwealth's per capita cost increase was the result of this enrollment shift.

Medical claims, exclusive of pharmacy claims, for services and supplies received in calendar year 2002 averaged $168.39 per covered life on a monthly basis. Monthly paid claims per covered life for prescription drugs averaged $45.52 in calendar year 2002. In aggregate, the average monthly paid claims per covered life for services received in 2002 was $213.91. The average monthly premium paid by the Commonwealth and individuals insured under the Public Employee Health Insurance Program increased from $188.68 in 2000 to $206.10 in 2001 and $231.83 in 2002.

While the Commonwealth's 2001 premium increase of 9.1% was lower than the cost increase reported by employers that participated in Mercer's 2001 *National Survey of Employer-Sponsored Health Plans*, the Commonwealth's 2002 premium increase of 12.5% was about one percentage point higher than the average reported by 2002 survey respondents. Survey respondents reported aggregate healthcare costs increases of:

- 11.5% nationally for employers in all industry groups with 500 or more employees (12.1% in 2001),
- 11.6% for state government employers (13.8% in 2001), and
- 11.5% for employers located in the South (U.S. census region) with 500 or more employees (12.7% in 2001).

Part of the reason that the Commonwealth's 2002 premium increases outpaced market averages is due to the fact that the Commonwealth did not change any of the provisions of its health plan offerings in 2002 and many other employers did. Furthermore, payments issued by the Commonwealth's health insurance carriers to healthcare providers who provided medical supplies and services to members of the Commonwealth's Public Employee Health Insurance Program increased 14.0% in 2001 and 15.0% in 2002, indicating that, while the Commonwealth's health insurance premiums may have increased more in 2002 than the market average, the Commonwealth and its members received a "better value" for their health care dollar in 2002 than 2001 or 2000. In 2001, roughly 90.2 cents of every dollar paid to the Commonwealth's insurance carriers went to healthcare providers. In 2002, roughly 92.3 cents of every dollar paid to the Commonwealth's insurance carriers went to healthcare providers.

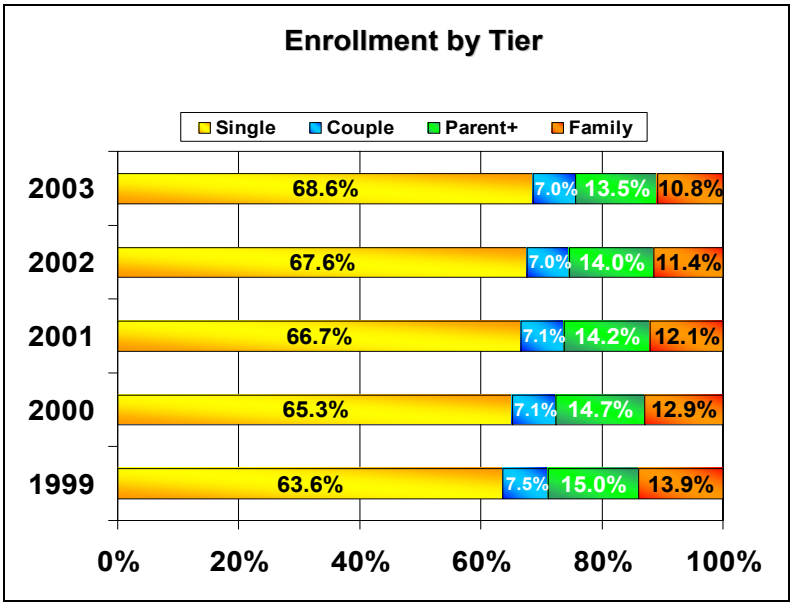
Enrollment Analysis

While the number of employees/retirees in the Commonwealth Group electing health insurance increased on average from 134,112 to 137,024 from 2000 to 2001 and to 139,016 in 2002, the average number of covered lives remained basically constant. In 2000, on average, 17,263 employees/retirees elected Family coverage (coverage for a spouse and one or more children), down from 18,329 in 1999. In 2001, this decreased further to 16,530 and, in 2002, further to 15,830. The number of individuals enrolled in Couple and Parent Plus coverage remained relatively unchanged from 2000 to 2002, while the number of individuals electing Single coverage increased 2.8%.

As illustrated in Exhibit V, the percentage of individuals within the Public Employee Health Insurance Program enrolled in Single coverage has consistently increased since 1999, while the percentage of individuals electing dependent coverage, particularly family coverage has consistently declined. This is likely the result of the impact of the Commonwealth's contribution structure:

- the Commonwealth pays the full cost of Single coverage under the lowest cost Option A, but does not directly fund any portion of the cost of dependent health insurance coverage, and
- a continuing increase in the number of retirees covered under the program.

Exhibit V



Source: Commonwealth's enrollment reported by OPEHI and aggregated by MedStat.

Group Composition

The composition of the Commonwealth Group enrolled in health insurance has changed with respect to the key groups that comprise the Commonwealth Group. Like 2000 over 1999, the number of insured individuals actively employed by state agencies, school boards, and health departments declined from 2000 to 2001. However, the number of individuals insured through KERS and KTRS increased measurably from 1999 to 2000 (10.3%) and from 2000 to 2001 (7.2%). As illustrated in Exhibit VI below, this trend continued in 2002 and still continues in 2003. While retirees and their covered dependents comprised 14.3% of the total insured Commonwealth Group in 1999, by the end of the first quarter of 2003, they comprised 19% of the group.

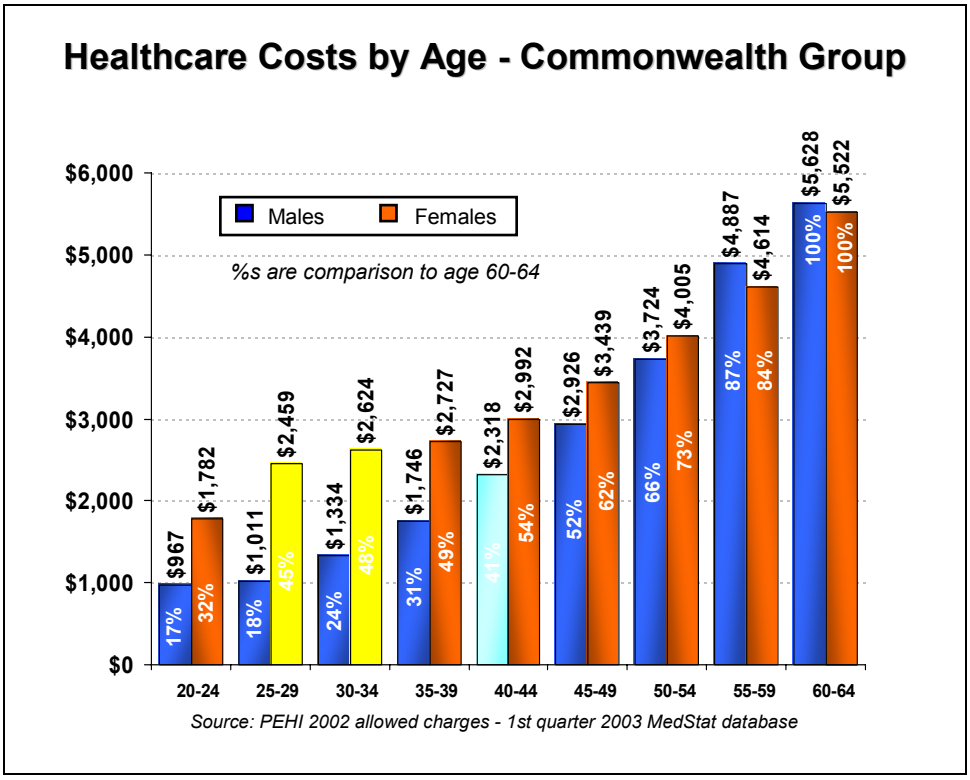
Exhibit VI

	Average Covered Lives by Group 2001, 2002 and 2003 – 1st Quarter							
	2001		2002		% Change	2003 – 1st Qtr		% Change
	Average Lives	% of Total	Average Lives	% of Total		Average Lives	% of Total	
State Employees	58,764	26.0%	57,750	25.6%	(1.7%)	56,112	24.9%	(2.8%)
School Boards	118,501	52.5%	116,038	51.4%	(2.1%)	114,064	50.5%	(1.7%)
Health Depts.	4,127	1.8%	4,091	1.8%	(0.9%)	4,120	1.8%	0.7%
KERS	22,313	9.9%	23,895	10.6%	7.1%	25,599	11.3%	7.1%
KTRS	16,028	7.1%	16,842	7.5%	5.1%	17,299	7.7%	2.7%
KCTCS	2,968	1.3%	3,157	1.4%	6.4%	3,386	1.5%	7.3%
Quasi/Local Govt.	1,454	0.6%	2,834	1.3%	94.9%	4,389	1.9%	54.9%
COBRA	1,466	0.6%	988	0.4%	(32.6%)	773	0.3%	(21.8%)
Total	225,621		225,708		0.0%	225,742		0.0%

Source: Commonwealth's enrollment aggregated by MedStat.

Due to the impact that age has on individuals' health care costs, as noted the past two years, this trend has significant cost implications for the Commonwealth's Public Employee Health Insurance Program. As illustrated in Exhibit VII below, in 2002, the average health care expenses incurred by a male in the Commonwealth's program whose age was between 60 and 64 ($5,628) was almost six (6) times that of a male between the ages of 20 and 24 ($967). While not quite as pronounced, the average health care expenses incurred by a female in the Commonwealth's program whose age was between 60 and 64 ($5,522) was over three (3) times that of a female between the ages of 20 and 24 ($1,782).

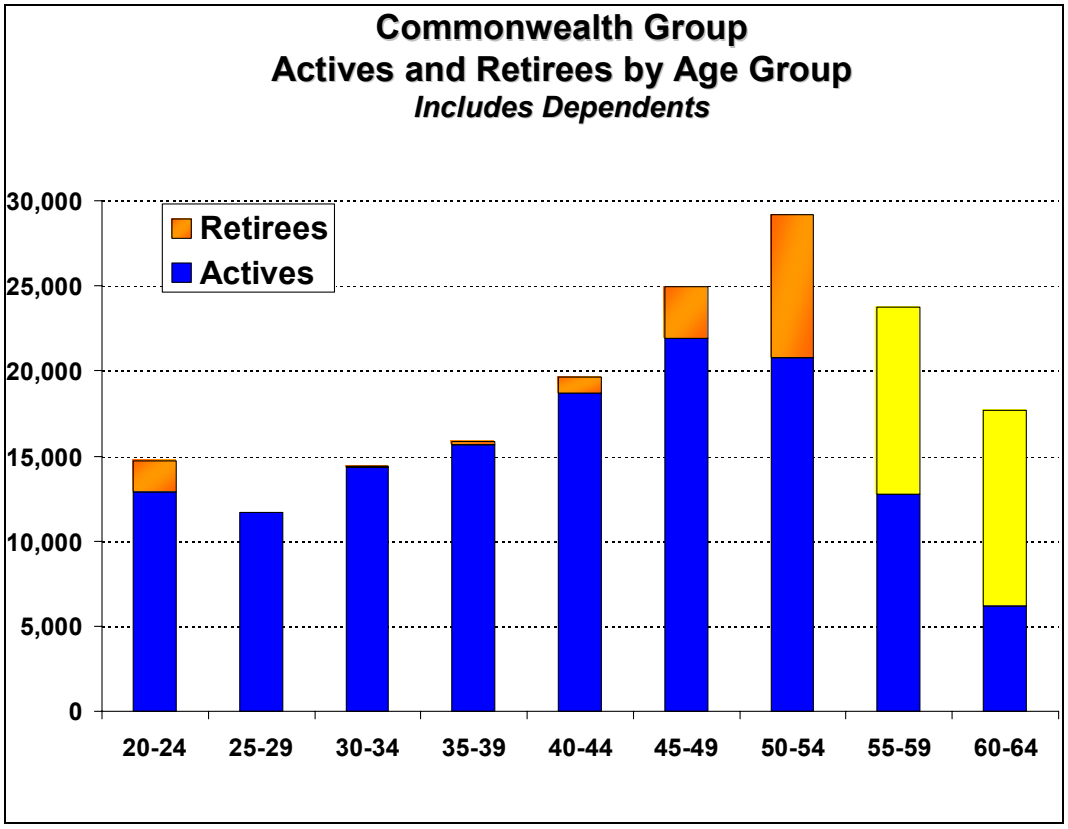
Exhibit VII



Source: Claims reported by the Commonwealth's insurers and enrollment reported by OPEHI and compiled by MedStat.

As expected, retirees and their dependents comprise a much larger portion of the Commonwealth group at older ages, with little corresponding membership at younger ages. This is illustrated in Exhibit VIII. Therefore, it is not surprising that the average 2002 healthcare expenses incurred by retirees and their dependents were 84% higher than the average healthcare expenses of active employees and their dependents.

Exhibit VIII



Source: Enrollment reported by OPEHI and compiled by MedStat.

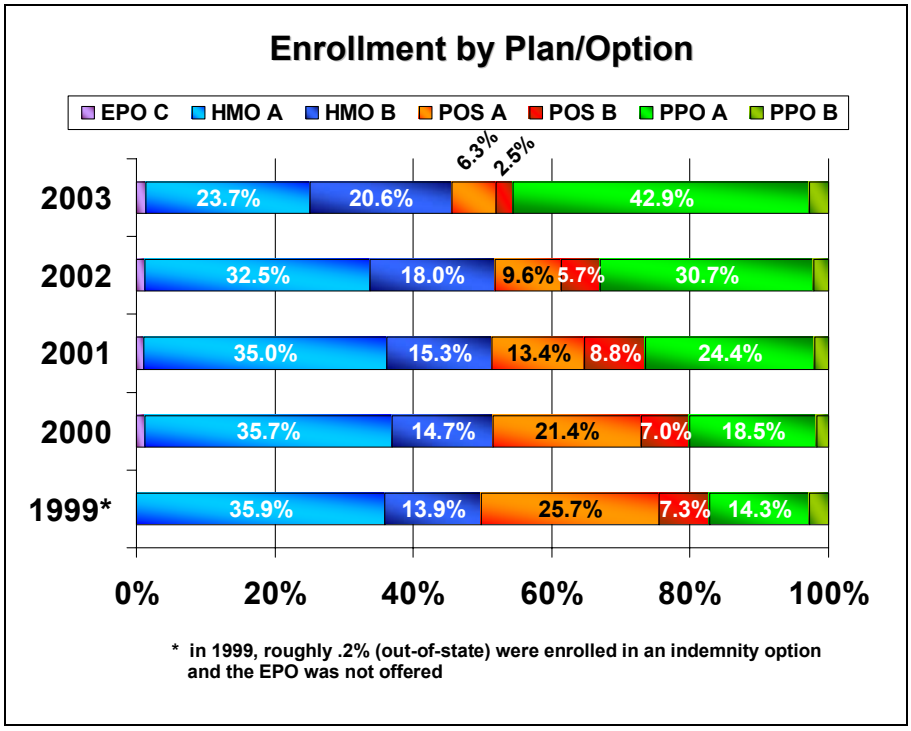
While still not a significant percentage of the total group that participates in the Commonwealth's Public Employee Health Insurance Program, the number of Kentucky Community and Technical College System (KCTCS) insured individuals continues to increase significantly. When KCTCS was formed as an entity separate from the University of Kentucky, individuals in this group were given the option of remaining in the UK benefits package or joining the Commonwealth Group. Individuals hired after this separation have only been eligible to join the Commonwealth's health insurance program. Therefore, since 1999, this group has grown from 2,340 covered lives to 3,386 by the end of the first quarter of 2003.

The number of individuals employed by quasi/local government agencies that are insured under the Commonwealth's Public Employee Health Insurance Program has more than tripled since 2001.

Enrollment by Option

The Commonwealth Group's enrollment by plan and option from 1999 through the first quarter of 2003 is illustrated below in Exhibit IX.

Exhibit IX



Source: Commonwealth's enrollment aggregated by MedStat.

The percentage of Commonwealth group members enrolled in HMO Option A remained relatively steady from 1999 through 2001. This began to decline noticeably in 2002 (from 35% to 32.5%), with a more pronounced decline in 2003 (from 32.5% in 2002 to 23.7% in 2003). Due to a shift to the HMO B option in 2002, the aggregate percentage enrolled in HMO options (both A and B) did not decline until 2003. Until 2003, around 50% of Commonwealth group members chose to enroll in an HMO option. In 2003, this declined to 44.3%. The HMO B option enrollment percentage has increased steadily since 1999 (from 13.9% in 1999 to 20.6% in 2003).

Point of Service (POS) enrollment has declined dramatically each year since 1999. From a high of 33% of the group in 1999, the percentage enrolled in a POS option had declined to only 8.8% by the first quarter of 2003.

As the POS options are the most expensive options that the Commonwealth offers in areas where a choice of plan types is available, it is likely that premium cost increases have been the primary factor in the POS enrollment decline. Similarly, the increase in premium differential between the HMO and PPO options over the years has likely led to the decline in aggregate HMO enrollment and the shift to the HMO B option.

The decline in POS enrollment in 2001 was offset by an increase in Preferred Provider Organization (PPO) Option A enrollment. PPO Option A enrollment grew from 18.5% in 2000 to 24.4% in 2001. In 2002, PPO Option A enrollment increased significantly to 30.7%. This increase was even more dramatic in 2003 when PPO Option A enrollment grew to almost 43% of those enrolled in the Commonwealth's Public Employee Health Insurance Program. The percentage enrolled in the PPO B option has hovered around 2% to 3% since 1999.

The percentage enrolled in the EPO plan, first introduced in 2000, remained virtually constant from 2000 through the first quarter of 2003 (around 1% of the group).

Overall, there has been a continued shift from the higher priced options, HMO A option and POS options, to the lower cost HMO B and PPO options.

As discussed in the section titled, Impact of Choice on the Commonwealth's Health Insurance Costs, the continued shift to the PPO Option A may result in a substantial change in premiums at some point in the future.

Enrollment by Insurer

The primary change in enrollment by insurance carrier from 2000 to 2001 resulted from the return of Aetna as an offering in 2001 and the exit of Pacificare and Advantage Care from the Kentucky insurance market.

Of the carriers who offered coverage in both 2000 and 2001, only Bluegrass Family Health's (BFH) enrollment percentage increased in 2001. This was due to:

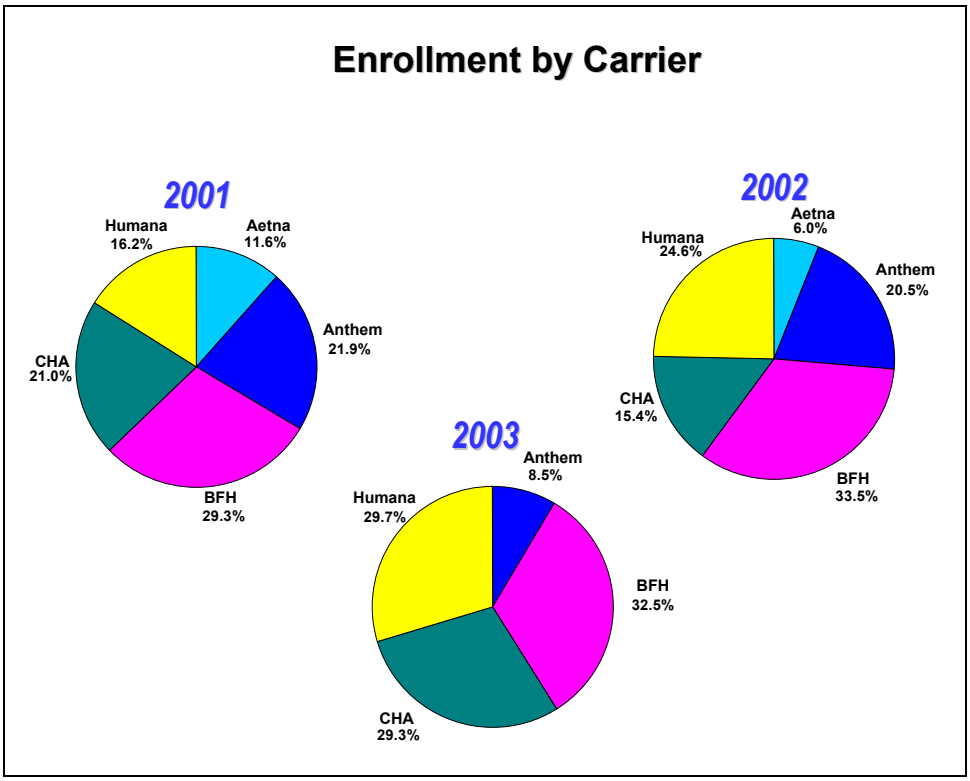
- an increase in the number of counties in which Bluegrass Family Health was offered from 58 in 2000 to 67 in 2001,
- a decline in the number of counties in which CHA was offered, and
- the demise of Advantage Care.

In 2001, CHA was offered in 59 counties, down from 78 in 2000. This was the primary cause of the decrease in CHA's enrollment percentage from roughly 25% in 2000 to 21% in 2001. Additionally, with an HMO A single premium rate that was $38.54 less per month than CHA's, Aetna's re-entrance created more competition for CHA in Northern Kentucky.

Both Anthem and Humana increased the number of counties in which they were offered in 2001. However, this did not result in an increase in either carrier's enrollment percentage in 2001. In fact, both lost enrollment in 2001, primarily due to the return of Aetna in 2001. Aetna's single HMO Option A rate was only one dollar more than the Commonwealth's contribution in the counties in which Aetna was offered. For only one dollar, individuals could purchase Single coverage in the HMO Option A through Aetna rather than receiving the Single PPO Option A at no cost. Also, the Aetna rate for HMO A Single coverage was $45.48 less monthly than Anthem's and $14.68 less than Humana's.

The charts in Exhibit X contrast the percentage of Commonwealth Group members enrolled in each carrier's offerings in 2001, 2002, and the first quarter of 2003.

Exhibit X



Source: Commonwealth's enrollment aggregated by MedStat

In 2002, the following factors affected the Commonwealth's enrollment in each carrier's offerings:

- Aetna was discontinued in eleven counties, as it scored lower in the Commonwealth's proposal evaluation than the other three carriers that bid in those counties and its premium increases in the counties in which it remained were disproportionate to those of the other carriers insuring members of the Commonwealth group. Where single coverage under the Aetna HMO A option was less than $5 more a month than the Humana PPO A option in 2001 and less than $1 more a month than the Bluegrass Family Health PPO A option, in 2002, single coverage under the Aetna HMO A option was over $38 more a month than the Bluegrass Family Health PPO A option and $43 more a month than the Humana PPO A option.
- While Anthem expanded the counties in which it offered coverage by nineteen counties, it encountered significant competition from Humana and/or Bluegrass Family Health in eight counties. In these eight counties, Anthem's single monthly PPO Option A premium rate exceeded these two carriers' PPO Option A rate by $60 to $75.
- Bluegrass Family Health's enrollment grew primarily from its expansion into thirteen additional counties, even though it was no longer available in one county where it was offered in 2001 (as it did not meet the Commonwealth's network requirements) and withdrew from offering HMO and POS options in two other counties.

- CHA's enrollment declined as it did not bid to offer coverage in four counties where it was the only carrier offered in 2001. Additionally, CHA withdrew from offering coverage in four other counties, changed from HMO and POS options to PPO in four other counties, and failed to meet the Commonwealth's network requirements in two counties. While CHA was newly offered in eight counties (HMO and POS), its premium rates were higher than other carriers' premiums for similar offerings.
- Humana's enrollment increased as:
  - it was newly offered in nine counties, although discontinued in eight counties where its enrollment was small, and
  - its PPO and HMO options were less expansive than competing carriers in virtually every county in which Humana was offered.

In 2003, the three most significant factors that affected the Commonwealth's enrollment were:

- Aetna declined to bid, thereby exiting eighteen counties where it was offered in 2002.
- Anthem's withdrawal from sixteen counties where it offered HMO and POS options in 2002 and from 34 counties in which it offered PPO options in 2002.
- CHA offered PPO options in 50 additional counties and was the lowest cost A option in 56 counties within the Commonwealth. Additionally, CHA's HMO and POS options became available in six counties where not offered in 2002, although discontinued in four counties.

Prescription Drug Experience

Consistent with marketplace trends, in 2002, while the gap in the percentage increase in prescription drug expenditures under the Commonwealth's Public Employee Health Insurance Program in comparison to the percentage increase for other covered services narrowed, the Commonwealth's prescription drug cost increase still outpaced the increase in cost for the other services covered under the Commonwealth's health insurance program.

This increase is attributable to four identifiable factors:

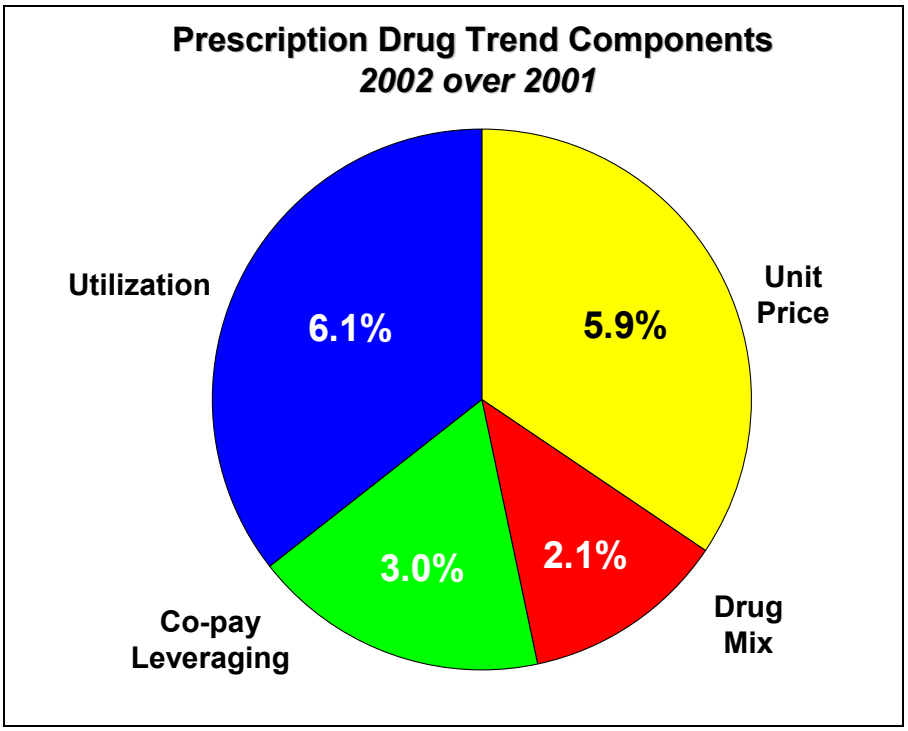
- an increase in unit price per prescription for the same drug (*Unit Price*),
- a change in the mix of drugs received by Commonwealth Group members (*Drug Mix*),
- co-payment leveraging – the impact of fixed dollar co-payments on the Commonwealth's health plan's cost in relation to unit price increases (*Co-pay Leveraging*), and
- an increase in the number of prescriptions received by Commonwealth Group members (*Utilization*).

Unit Price

As illustrated in Exhibit XI, unit price, as measured by comparing the price per prescription for all drugs utilized by Commonwealth Group health members, increased 5.9% from 2001 to 2002. This component of the Commonwealth's prescription drug expenditure increase is limited to the pure price increase that would have resulted if covered individuals received exactly the same

drugs in 2002 as were received in 2001. The increase in unit drug prices in 2002 of 5.9% was higher than the 2001 increase of 5.7% and the increase in 2000 of 4.1%.

Exhibit XI



Source: Claims and enrollment reported by the Commonwealth's insurers, compiled by OPEHI and MedStat and analyzed by Mercer.

Drug Mix

Over time, physicians' prescribing patterns and patients' preferences for certain prescription drugs change. This has been affected by three factors:

1) "direct-to-consumer" advertising by the pharmaceutical industry,
2) increases in the number of pharmaceutical representatives who call on physicians, and
3) an influx of new drugs into the marketplace.

To measure the impact that changes in the mix of prescriptions that Commonwealth Group health members received had on the Commonwealth's health plan's pharmacy costs, the average cost per prescription for 2001 was compared to 2002. After eliminating the change in pharmacy costs due to pure price increases (5.9%), the resulting increase in the cost per prescription from 2001 to 2002, due to the change in the mix of drugs received, was 2.1%, down from the 2001 increase of 3.1%. (In 2000, the increase in prescription drug cost due to drug mix was 3.5%).

Co-Pay Leveraging

When prescriptions are received from a network pharmacy, Commonwealth Group members pay a fixed dollar co-payment for each prescription. These co-payments have remained the same or declined since 1999. Due to the fact that the amount that Commonwealth Group members paid for prescriptions remained constant or declined while the cost per prescription increased, the amount paid by the Commonwealth's health plan, per prescription, has increased each year since 1999 at a higher rate than the total cost per prescription. In 2002, the leveraging resulting from the fixed dollar prescription drug co-payments in the Commonwealth's health insurance program resulted in an increase in prescription drug costs of 3%. The percentage increase due to co-pay leveraging was higher in 2002 than the 2.3% experienced in 2001 or the 2.4% increase experience in 2000.

Prescription Drug Utilization

The final component of the change in prescription drug expenditures in the Commonwealth's Public Employee Health Insurance Program is from the change in the number of prescriptions received by its members. The number of prescriptions covered by the Commonwealth's health plan increased 6.1% from 2001 to 2002. This was down from the increase of 7.8% from 2000 to 2001 and the 2000 increase of 6.8%. The average number of prescriptions per covered individual paid for by the Commonwealth's Public Employee Health Insurance Program is illustrated in Exhibit XII, along with a breakdown among single source brand name drugs, multi-source brand name drugs and generic drugs.

Exhibit XII

	Average Prescriptions per Person			% Change 2001 to 2002
	2000	2001	2002	
Scripts per Person	14.89	16.05	17.03	6.1%
Single Source Brand*	6.98	8.44	8.65	2.5%
Multi Source Brand*	2.00	1.16	1.16	0.0%
Generic*	5.68	6.20	6.95	12.1%

* excludes those not classified in one of these groups, so these categories total less than the overall scripts per person

Source: Claims and enrollment reported by the Commonwealth's insurers, compiled by OPEHI and MedStat and analyzed by Mercer.

Based on the available per member per month prescription drug utilization data available for 2000, 2001, and 2002:

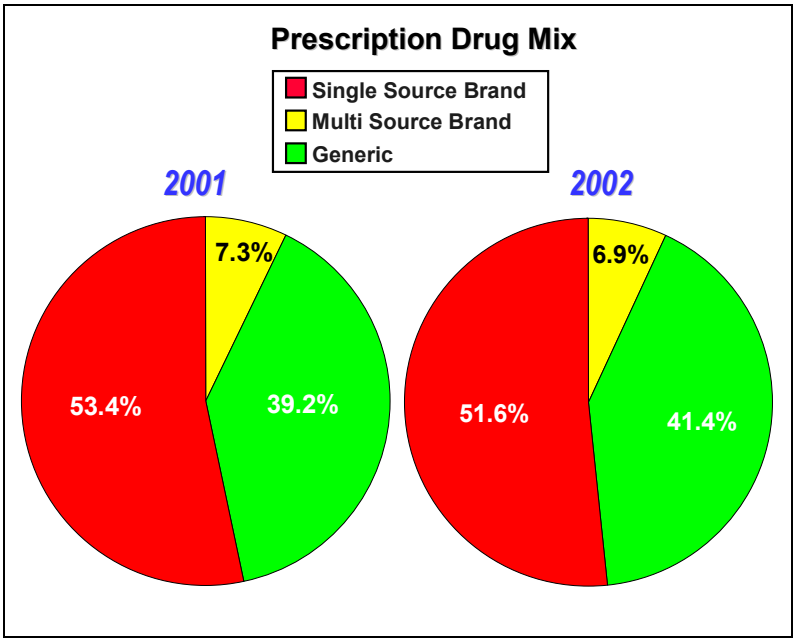
- The number of single-source brand name drugs received by Commonwealth Group members increased at the fastest pace in 2001, 20.9%. Fortunately, this growth slowed substantially in 2002 to only 2.5%.
- The number of multi-source brand prescriptions, those drugs for which an alternative generic drug is available, decreased 42% in 2001 and basically remained unchanged in 2002.
- Generic prescriptions, the least expensive type of prescription, increased in 2001, but at a much lower rate, 9.1%, than single-source brand drugs, which have a much higher cost. In 2002, at 12.1% this type of prescription had the highest percentage increase.

Note: As previously stated, the 2001 split between single source and multi-source brand name drugs has been restated by MedStat since the October 2002 report was issued.

While prescription drug utilization of members of the Commonwealth's Public Employee Health Insurance Program grew in 2002, the Commonwealth's prescription drug cost increase percentage in 2002 slowed from that experienced in 2001, due to heavier utilization of generic prescriptions.

As illustrated in Exhibit XIII, due to the unequal increase in utilization by type of prescription, the percentage of prescriptions received by Commonwealth Group members dispensed as single source brand name drugs decreased from 53.4% in 2001 to 51.6% in 2002. Multi-source brand name drugs declined from 7.3% of prescriptions received in 2001 to 6.9% in 2002. The generic prescription percentage continued to increase from 38.7% in 2000 to 39.2% in 2001 and 41.4% in 2002.

Exhibit XIII



Source: Claims and enrollment reported by the Commonwealth's insurers, compiled by OPEHI and MedStat, and analyzed by Mercer.

Prescription Drug Purchasing Cooperatives

To leverage their buying power, in recent years, both private sector and state government employers have joined together to form pharmacy benefit purchasing cooperatives. Pharmacy cooperatives have been able to ask for and receive superior financial arrangements, focused attention, and the specialized services that individual employers typically cannot demand. In general, through a pharmacy cooperative, an employer can usually save between 3% and 10% off the drug costs in its employee health benefits program through more competitive ingredient cost discount arrangements, lower dispensing fees, lower claims processing fees and enhanced rebates. Additionally, if the Commonwealth aggregated its pharmacy benefits under a single pharmacy benefit manager (PBM), it could apply consistent formulary, step-therapy and other utilization management arrangements to all members of the Public Employee Health Insurance Program. However, pharmacy cooperatives are typically **only** an alternative for employers that self-fund their employee healthcare benefits.

From a practical perspective, the Commonwealth should only consider a pharmacy benefit purchasing cooperative if it is willing to self-fund its entire health insurance benefit program as:

- Prescription drug benefit cost increases, for the Commonwealth and other employers, continue to outpace other healthcare benefit increases. From a risk perspective, entities usually prefer to insure their most volatile costs and self-insure costs that are more predictable and stable.
- If the Commonwealth insured its health benefits, other than prescription drugs, and self-funded its prescription drug benefits, it would have to maintain two eligibility and reconciliation administrative systems: one for the insured portion of its healthcare benefits and one for the self-funded portion.
- With its medical benefits insured (other than prescription drugs), the Commonwealth is more likely to encounter difficulties in convincing its insurance carriers to accept and load data from its cooperative PBM for use in helping its members manage their health conditions.
- The Commonwealth's insurance carriers may build more margin into their insured medical rates since they would have "less control" over members' prescription drug utilization.

Findings

Key trends for the 2002 plan year, in comparison to 2001, are:

- The Commonwealth's 2002 premium increase of 12.5% is higher than the average healthcare cost increase reported by employers that participated in Mercer's *National Survey of Employer-Sponsored Health Plans for 2002.* Survey respondents reported aggregate healthcare costs increases of:
  - 11.5% nationally for employers in all industry groups with 500 or more employees,
  - 11.6% for state government employers, and
  - 11.5% for employers located in the South (U.S. census region) with 500 or more employees.

- While the gap between the percentage increase in prescription drug expenditures (18.2%) and the percentage increase in prescription increase in other covered expenses in the Commonwealth's program (14.2%) narrowed in 2002, the increase in prescription drug expenditures still outpaced the increase in other covered expenses.
- As payments for the medical supplies and services received by Commonwealth Group members increased at a faster pace than premiums paid to the Commonwealth's health insurance carriers, the plan's overall loss ratio increased from 90.2% in 2001 to 92.3% in 2002. In 2002, a greater share of the Commonwealth's and Commonwealth Group members' premium payments went to pay healthcare providers than in 2001, leaving a smaller percentage of premium dollars to pay the insurers' operating expenses and contribute to their profits.
- While the number of employees and retirees insured under the Commonwealth's health insurance program increased roughly 1.5% in 2002, due to a decline in the number of individuals electing dependent healthcare coverage, the number of covered lives remained virtually the same as in 2001. The percentage of individuals electing dependent health insurance in the Commonwealth's program continues to decline, likely as a result of the Commonwealth's contribution policy.
- The number of active employees, excluding covered dependents, insured under the Commonwealth's health insurance program increased, on average, by roughly 400 individuals from 2001 to 2002. However, the number of covered retirees, excluding covered dependents, increased, on average, by almost 1,900. Retirees and their covered dependents comprised 14.3% of the total insured Commonwealth Group in 1999. This grew to 19.0% in 2002. This trend has long-term cost implications for the Public Employee Health Insurance Program, due to the impact of aging on healthcare consumption.
- While aggregate HMO enrollment (option A and B) remained relatively steady at around 50% of the enrolled population in 2002, there was a shift from Option A to Option B. In 2003, there was a further shift from Option A to Option B **and** a substantial decline in aggregate HMO enrollment to about 44% of the enrolled population. Point of Service (POS) enrollment continues to decline dramatically, from 33% in 1999 to only about 9% in 2003. PPO enrollment grew from roughly 20% in 2000 to almost 46% in 2003, with the majority of this increase occurring in PPO option A. Enrollment grew in this option from 14.3% in 1999 to 42.9% in 2003. Enrollment in the Exclusive Provider Option implemented by the Commonwealth January 1, 2000 has remained relatively steady.
- Enrollment among the Commonwealth's insurance carriers has shifted over the years in response to carriers' offerings and their pricing policies. However, by 2003, the majority of the Commonwealth's enrollment was concentrated in three carriers' offerings - Humana (30%), Bluegrass Family Health (33%) and CHA (29%). Anthem's enrollment declined to only about 9% of the group by 2003, due to its decision to only offer PPO options in a limited number of counties.
- The 2002 per capita increase in prescription drug expenditures in the Public Employee Health Insurance Program of 18.2% was higher than reported by participants in Mercer's *National Survey of Employer-Sponsored Health Plans for 2002.* Survey respondents reported aggregate prescription drug costs increases of:
  - 16.9% nationally for employers in all industry groups with 500 or more employees,

- 15.5% for state government employers, and
- 16.6% for employers located in the South (U.S. census region) with 500 or more employees.

Note: As noted in the October 2002 report, the increases reported by survey respondents reflect the net increase in cost after taking into account the increases in prescription drug cost sharing implemented by some survey respondents. The Commonwealth's prescription drug co-payments have remained the same, while some survey participants' cost-sharing has increased, at least partly explaining why the Commonwealth's prescription drug expenditures rose at a faster pace than the market.

Based on data reported by the Commonwealth's insurance carriers and aggregated by MedStat, the Commonwealth's prescription drug increase is attributable to four quantifiable factors:

- an increase in unit price per prescription for the same drug – accounted for a 5.9% increase in prescription drug costs,
- a change in the mix of drugs received by Commonwealth Group members – accounted for a 2.1% increase in prescription drug costs,
- co-payment leveraging, the impact of fixed dollar co-payments on the Commonwealth's health plan's cost in relation to unit price increases – which accounted for an increase of 3.0%, and
- utilization – an increase of 6.1%.

Conclusions

- Based on its historical experience and increasing percentage composition of retirees, the Commonwealth's health insurance costs are expected to continue to increase at levels well in excess of general inflation for the foreseeable future.

- Without a change in the Commonwealth's contribution policy – paying the full cost of single coverage for the lowest cost A option available in each county with no subsidy for dependent premiums – it is anticipated that the percentage of Public Employee Health Insurance Program members enrolling their dependents will continue to decline, as it has continually since 1999.

- Due to expected future health insurance premium increases, it is anticipated that enrollment in the Commonwealth's HMO A and POS A options will continue to decline and enrollment in the PPO A option will continue to increase.

- Participation in a pharmacy benefit purchasing cooperative could lower the Commonwealth's prescription drug costs by 3% to 10% and provide more consistent pharmacy benefit administration (formularies, step-therapy, quantity limits, etc.) to members of the Public Employee Health Insurance Program. However, from a practical perspective, participation in a pharmacy benefit purchasing cooperative will only be an option for the Commonwealth if it decides to self-fund its health insurance benefits at some point in the future.

Impact of Choice on Commonwealth's Health Insurance Costs

There are several ways in which choice can impact the cost of the Public Employee Health Insurance Program:

- Entities that choose to cover their retirees, but not active employees, under the Public Employee Health Insurance Program raise the program's average cost per member.
- Selection of the higher priced HMO A and POS A offerings by members of the group whose health care expenses, on average, are higher than the average of the group overall has adversely impacted the premiums charged by the Commonwealth's insurers for these options. This member selection may have helped to dampen the Commonwealth's health insurance cost increases over the past few years. However, as members migrate from the HMO A and POS A options to the PPO A option and from the PPO A to PPO B option due to premium increases, as occurred in 2003, it is anticipated that PPO A premiums will be adversely impacted, thereby negatively impacting the Commonwealth's future health insurance costs.
- If entities are allowed to choose whether to insure their active employees under the Public Health Insurance Program or not, it is likely that only those entities that can obtain lower costs through the Commonwealth's program will do so.
- The policies applied by the various entities that participate in the Commonwealth's Public Employee Health Insurance Program can negatively impact the cost of the program. For example, if an entity allows its employees to enroll in or discontinue coverage, without restriction, some employees will only elect coverage during periods when they know they will have expenses, thereby selecting against the plan and increasing program costs for all members.

Retiree Selection Impact

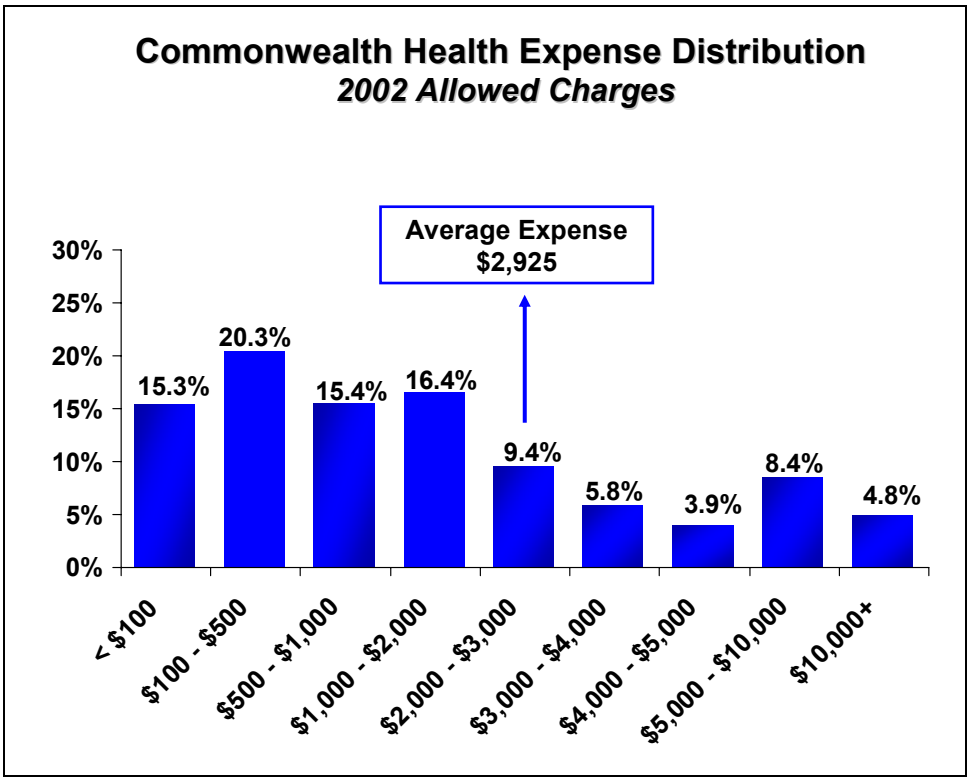
As indicated in the Board's October 2002, retirees of groups whose active employees do not participate in the Commonwealth's Public Employee Health Insurance Program, and their covered dependents, added about $15-$16 million in excess cost that was absorbed by the Commonwealth or other Public Employee Health Insurance Program members in 2001. This finding was substantiated by an independent analysis conducted by The Segal Company at the request of the Interim Joint Committee on State Government. In a October 2002 report, The Segal Company indicated that claims for retirees of groups whose active employees do not participate in the Commonwealth's Public Employee Health Insurance Program (termed "unescorted retirees" by Segal), and their covered dependents, added $14.1 million in excess claims to the Commonwealth's program in 2001.

Based on the distribution of healthcare costs by age in the Commonwealth's program in 2002 as reflected in Exhibit VII and the 2002 distribution of all retirees and active employees by age and gender in Exhibit VIII, a similar result, increased by the overall claim cost increase in the Commonwealth's program, would be expected if this analysis was updated to reflect 2002 experience.

Experience Variation Among the Commonwealth's Health Options

Individuals' health care claims vary significantly, from $0 to over $250,000 in a year. Exhibit XIV, illustrates this distribution for the individuals covered under the Commonwealth's health insurance program in 2002, exclusive of capitations.

Exhibit XIV

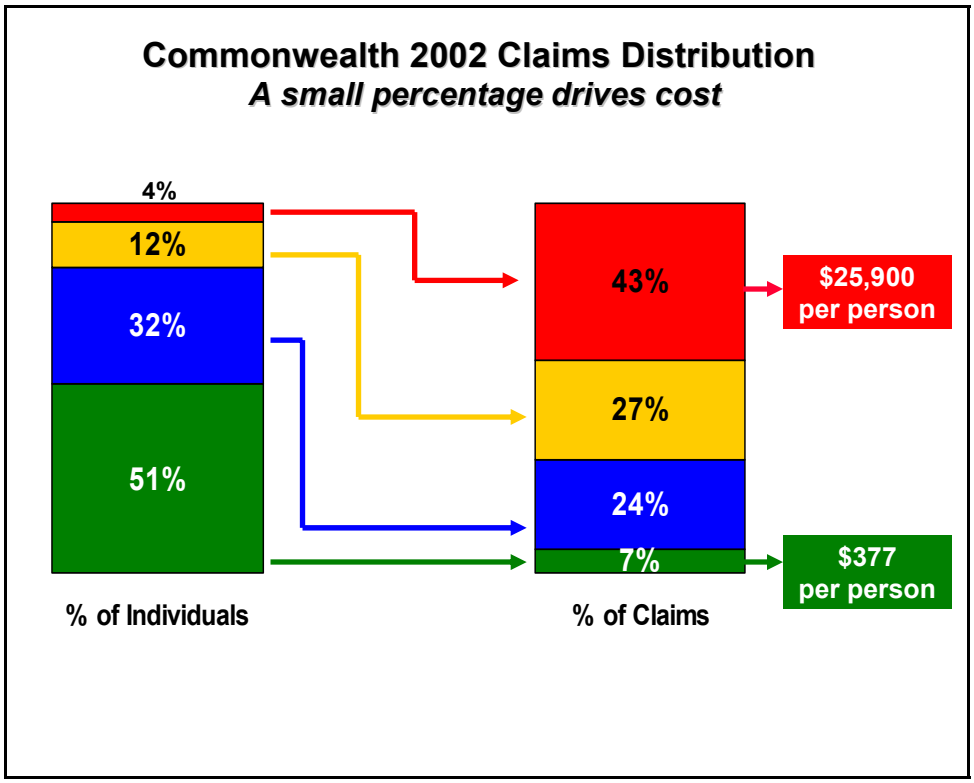


Source: Claims and enrollment reported by the Commonwealth's insurers, compiled by OPEHI and MedStat, and analyzed by Mercer.

While the average allowed health expenses per covered individual in 2002 for members of the Public Employee Health Insurance Program were $2,925, 15.3% of covered individuals had expenses of less than $100 and an additional 20.3% had expenses between $100 and $500. In total, about 75% of the Commonwealth group had health care costs that were "below average".

In the Commonwealth's program in 2002, like the typical employer's health insurance program, a very small percentage of individuals generated a large proportion of the health plan's expenses. This is illustrated in Exhibit XV, which reflects the same information as presented in Exhibit XIV in a different manner. Fifty-one percent (51%) of the members in the Commonwealth's program generated only 7% of the program's health expenses (shown in green) while four percent (4%) generated forty-three (43%) of the program's expenses (shown in red).

Exhibit XV



Source: Claims and enrollment reported by the Commonwealth's insurers, compiled by OPEHI and MedStat, and analyzed by Mercer.

When a choice of health plans is offered, individuals will seek to maximize their value by minimizing their total out-of-pocket costs (premiums + deductibles + co-payments, etc.), resulting in adverse selection. And, although individuals' health care claims vary significantly, from $0 to over $250,000 in a year, insurance premiums are based on the average claims cost of the covered population. Therefore, when plan choices are offered, premium rates need to reflect potential changes in enrollment, or the premiums collected won't cover the health care claims of the covered population.

The 2002 average allowed charges (exclusive of capitations) for members of the Commonwealth's Public Employee Health Insurance Program varied significantly among the health plan options offered by the Commonwealth. These averages are presented in Exhibit XVI, along with a comparison of how the average expense of Option B participants compared to the average expense of Option A participants in the same type of plan (HMO, POS, PPO).

Exhibit XVI

2002 Average Allowed Charges Commonwealth's Public Employee Health Insurance Program		
Plan Option	**Average Allowed Charges**	**Comparison of B Option Charges to Comparable A Option Charges**
EPO	$1,355	
PPO B	$1,779	60% of PPO A Charges
POS B	$2,015	47% of POS B Charges
HMO B	$2,029	62% of HMO A Charges
PPO A	$2,945	
HMO A	$3,251	
POS A	$4,258	

As illustrated in Exhibit XVI, the 2002 average expense incurred by members of the Public Employee Health Insurance Program who enrolled in the lower cost B options were only 47% to 62% of the average expenses incurred by corresponding A option enrollees, before taking into account the differences in benefits payable by each plan. This result supports the fact that members of the Commonwealth's Public Employee Health Insurance Program, like other employee groups, when offered a choice of health plans will elect coverage in a manner that maximizes their value. In general, those with lower health expenses will elect lower cost options that provide lower benefits or more limited healthcare provider networks, while those with higher health expenses will elect higher cost options that provide higher benefits or a broader selection of healthcare providers.

In some areas, only the PPO and EPO options were available to Commonwealth members in 2002. While this fact mitigated some of the selection cost between the lower cost PPO A option and the higher cost HMO A and POS A options, HMO A option participants' average health expenses, exclusive of capitations, in 2002 were over 10% higher than the average health expenses incurred by PPO A option participants and POS A option participants' average health expenses were almost 45% higher than those of PPO A option participants. As HMO A and POS A participants who incur higher healthcare expenses shift into the PPO A option, as occurred in 2003, the average allowed charges of PPO A option participants will increase. This is likely to negatively impact PPO A premium rates, and therefore the Commonwealth's health insurance contribution, at some point in the future.

Entity Participation Selection Impact

Members of the Public Employee Health Insurance Program generally select the option available to them that maximizes the benefit they receive (minimizing their total out-of-pocket expenses), thereby increasing the cost of the program. Similarly, if entities are allowed to choose whether to insure their employees under the program or not, a major factor in each entity's decision will be whether it can obtain lower costs by doing so. Unfortunately, since health insurance premiums are based on the health insurance claims of the group being covered, generally, if an

entity's cost would be lower under the Commonwealth's program, the average health care expenses of the entity's members will be higher than the average health expenses of Commonwealth group members overall. This premise is supported by the fact that the 2002 average allowed charges of members of the Public Employee Health Insurance Program of quasi/local governmental bodies were 8% higher than the average for all other active employees. Therefore, to the extent possible, it is important for the Public Employee Health Insurance Program to limit, or eliminate, the ability for entities to enter or exit the program or choose just to insure segments of their employee/retiree population.

Impact of Administrative Policies

The policies applied by the various entities that participate in the Commonwealth's Public Employee Health Insurance Program can negatively impact the cost of the program. For example, if an entity allows its employees to enroll in or discontinue coverage without restriction, some employees will only elect coverage when they know they will have expenses, thereby selecting against the plan and increasing the program's costs for all members. Indicative of this type of selection, the 2002 average allowed charges of COBRA beneficiaries were 26% higher than the average for the group overall.

Furthermore, there are specific requirements in Internal Revenue Code laws and regulations that must be met for employee benefits, including pre-tax contributions for health insurance coverage, to maintain their tax-favored status.

Conclusions

- Allowing entities to cover only their retirees under the Public Employee Health Insurance Program raises the cost of the program for all other participating entities and their members. For 2001, claims of retirees of groups whose active employees do not participate in the Commonwealth's Public Employee Health Insurance Program (termed "unescorted retirees" by The Segal Company), and their covered dependents, added between $14 and $16 million in excess claims to the Public Employee Health Insurance Program.
- As typically occurs, when offered a choice of health insurance options, in general, members of the Commonwealth's Public Employee Health Insurance Program have selected the healthcare options that minimize their total out-of-pocket cost. To date, the selection of HMO A and POS A by members with higher average healthcare expenses has helped lower the Commonwealth's cost, since the Commonwealth funds the lowest cost A option available in each county, which, for the most part, has been the PPO A option. However, as enrollment migrates to the PPO A option, as occurred in 2003, so will the higher costs of HMO A and POS A members, thereby exacerbating PPO A premium increases and the increase in the Commonwealth's health insurance expenditures.
- When allowed to choose whether or not to participate in the Public Employee Health Insurance Program, entities will only do so if it is cost advantageous to them. Although an entity may experience lower costs in the Commonwealth's program due to lower fixed costs from the size of the Public Employee Health Insurance Program, this may also be the case because the entity's average health insurance claims are higher than that of the Commonwealth. In fact, the 2002 average allowed charges of members of the Public

Employee Health Insurance Program of quasi/local governmental bodies were 8% higher than the average for all other active employees. Therefore, to the extent possible, it is important for the Public Employee Health Insurance Program to limit, or eliminate, the ability for entities to enter or exit the program or choose just to insure certain segments of their employee/retiree population.

- The policies applied by the various entities that participate in the Commonwealth's Public Employee Health Insurance Program can negatively impact the cost of the program. For example, if an entity allows its employees to enroll in or discontinue coverage without restrictions, some employees will only elect coverage when they know they will have expenses, thereby selecting against the plan and increasing the program's costs for all members. Indicative of this type of selection, the 2002 average allowed charges of COBRA beneficiaries were 26% higher than the average for the group overall. Furthermore, there are specific requirements in Internal Revenue Code laws and regulations that must be met for employee benefits, including pre-tax contributions for health insurance coverage, to maintain their tax-favored status.

Market Comparison

The October 2001 Board report included a comprehensive comparison of the Commonwealth's Public Employee Health Insurance Program to that of other states. This year, this report section reflects a comparison of the Commonwealth's 2002 health plan provisions to the results of Mercer Human Resource Consulting's 2002 *National Survey of Employer-Sponsored Health Plans*.

Exhibit XVII reflects how the provisions of the average large employer's (defined as those employers with 500 or more employees) HMO and PPO plan's provisions changed from 2000 to 2002.

Exhibit XVII

	Employers Nationally with 500 or More Employees					
	HMO			PPO In-Network		
	2000	2001	2002	2000	2001	2002
Hospital inpatient	$ 0	$ 0	$ 0*	*Not available*	*Not available*	15%
Physician office	$ 10	$ 11	$ 12	$ 10	$ 15	$ 15
Rx – retail						
Generic	$ 8	$ 9	$ 10	$ 8	$ 9	$ 10
Brand	$ 16	$ 17	$ 19	$ 16	$ 17	$ 19
Non Formulary	$ 29	$ 31	$ 35	$ 29	$ 31	$ 35
Annual deductible	N/A	N/A	N/A	$ 250	$ 250	$ 250
Annual out-of-pocket max	*Not available*	*Not available*	*Not available*	$ 1,250	$ 1,300	$ 1,350
Employee Contributions						
Employee	$ 39	$ 47	$ 49	$ 48	$ 56	$ 57
Family	$ 162	$ 172	$ 187	$ 184	$ 191	$ 202
Self Funded	7%	13%	14%	67%	67%	68%

*** in 2002, 39% (65% in the South) required a co-payment, with the median being $240**

Source: Mercer Human Resource Consulting's National Survey of Employer-Sponsored Health Plans.

Similarly, Exhibit XVIII reflects the average provisions of the HMO and PPO offerings of states that responded to Mercer's survey, as they have changed over time.

Exhibit XVIII

	State Government Employers					
	HMO			PPO In-Network		
	2000	2001	2002	2000	2001	2002
Hospital inpatient	$ 0	$ 0	$200*	*Not available*	*Not available*	20%
Physician office	$ 9	$ 9	$ 12	$ 10	$ 15	$ 13**
Rx – retail						
Generic	$ 8	$ 7	$ 8	$ 8	$ 7	$ 8
Brand	$ 14	$ 17	$ 18	$ 14	$ 17	$ 18
Non Formulary	$ 24	$ 31	$ 33	$ 24	$ 31	$ 33
Annual deductible	N/A	N/A	N/A	$200	$250	$300
Annual out-of-pocket max	*Not available*	*Not available*	*Not available*	$1,125	$1,250	$ 1,450
Employee Contributions						
Employee	$ 25	$ 29	$ 41	$ 30	$ 45	$ 48
Family	$ 125	$ 128	$ 181	$ 127	$ 169	$ 227
Self Funded	15%	18%	12%	75%	70%	79%

* in 2002, 50% required hospital inpatient cost sharing

** in 2001, 45% required co-insurance (48%) in 2002); and in 2001, 5% had no Dr. office visit cost-sharing (all required in 2002)

Source: Mercer Human Resource Consulting's National Survey of Employer-Sponsored Health Plans.

As reflected in Exhibits XVII and XVIII, from 2000 to 2002, in both private sector and state government employers' health plans, members' co-payments and other cost-sharing provisions increased substantially. The percentage changes in members' cost-sharing provisions from 2000 to 2002 are reflected in Exhibit XIX.

Exhibit XIX

	National Employers		State Governments	
	HMO	PPO	HMO	PPO
Physician office	20%	50%	33%	30%
Rx – retail				
Generic	25%		--	
Brand	19%		29%	
Non Formulary	21%		38%	
Annual deductible	N/A	--	N/A	50%
Annual Out-of-pocket max	N/A	8%	N/A	29%
Employee Contributions				
Employee	26%	19%	64%	60%
Family	15%	10%	45%	79%

Increases in member cost sharing were more pronounced in state government employers' plans, as these plans moved more in line with those of private sector employers.

In contrast, the Commonwealth's health plan provisions have basically remained the same since 1999, with the majority of the changes constituting improvements in benefit provisions. These revisions include:

- the addition of the EPO option in 2000;
- the 2000 addition of a feature to reduce members' prescription drug co-payments once a member and all his/her covered family members had paid 50 co-payments in a year (changed to 75 co-payments for 2004);
- a reduction in PPO Option B prescription drug co-payments in 2001;
- in 2001, a revision to PPO Option A members' cost sharing for diagnostic testing, in a setting other than a physician's office, from 20% co-insurance after meeting the annual deductible to a $10 co-payment per visit;
- in 2001, the elimination of all day and visit limits applicable to behavioral health services; and
- the addition of a mail order pharmacy feature in 2003.

The lone reduction in benefit coverage provisions since 1999 was the elimination of coverage for routine vision and dental care services in the A options that occurred in 2003.

As summarized in Exhibit XX, in comparison to the "typical" large employer and state government employer HMO offerings in 2002, the Commonwealth's 2003 HMO offerings:

- required a per admission co-payment of $100 while other large employers nationally required no member cost sharing for this service and other states, on average, required a $200 per admission co-payment;
- had a lower physician's office visit co-payment; and
- required comparable employee contributions for single coverage, however, much larger family coverage contributions from employees.

Exhibit XX

	HMO			PPO In-Network		
	Large ERs 2002	States 2002	Kentucky 2003*	Large ERs 2002	States 2002	Kentucky 2003*
Hospital inpatient	$ 0	$200	$100	15%	20%	20%
Physician office	$ 12	$ 12	$ 10	$ 15	$ 13	$ 10
Rx – retail						
Generic	$ 10	$ 8	$ 10	$ 10	$ 8	$ 10
Brand	$ 19	$ 18	$ 15	$ 19	$ 18	$ 15
Non Formulary	$ 35	$ 33	$ 30	$ 35	$ 33	$ 30
Annual deductible	N/A	N/A	N/A	$250	$300	$250
Annual out-of-pocket max	*Not available*	*Not available*	$1,000	$1,350	$ 1,450	$1,250
Employee Contributions						
Employee	$ 49	$ 41	$ 39 - $ 52	$ 57	$ 48	$ 0
Family	$ 187	$ 181	$518 - $565	$ 202	$ 227	$404 - $596
Self Funded	14%	12%	No	68%	79%	No

*** Kentucky plan provisions and employee contributions reflect HMO A and PPO A.**
Employee contributions reflect the lowest cost HMO A and PPO A option available in a county.

Source: Mercer Human Resource Consulting's National Survey of Employer-Sponsored Health Plans.

With respect to its PPO offerings:

- the Commonwealth's coinsurance for hospital services is comparable to that of other states' PPOs, yet higher than other national employers in general;
- the Commonwealth's 2003 physician office visit co-payments are lower than Mercer's survey indicates were the norm in 2002;
- the Commonwealth had a annual deductible in 2003 that was comparable to market levels in 2002;
- had an out-of-pocket limit on member cost sharing in 2002 that was lower than 2003 market levels; and
- the Commonwealth required much lower employee contributions for single coverage, yet much higher employee contributions for family coverage.

With respect to its prescription drug coverage, the Commonwealth's:

- 2003 generic prescription drug co-payments were comparable to 2002 market levels for national employers, yet higher than the norm in other states; and
- its 2003 brand and non-formulary co-payments were below 2002 market norms.

Furthermore, while not reflected in the exhibits:

- the provision in the Commonwealth's plans that limit members' prescription drug co-payments annually is unique and more generous than market norms;
- the Commonwealth's retiree medical eligibility and single coverage contribution requirements are generous in comparison to the market; and
- the Commonwealth's policy of funding $234 monthly into a healthcare flexible spending account for eligible employees who waive coverage under the Commonwealth's health insurance program is extremely generous in comparison to the market, where the norm is not to provide any other benefit to those who waive health insurance.

Overall, with the exception of its dependent health insurance contributions, the Commonwealth's health insurance program is more generous than the median of the large employer market nationally and the average of other state governments. However, the Commonwealth's dependent health insurance premium contributions are substantially higher than market levels (2 to 3 times market levels).

Conclusions

With the exception of dependent health insurance contributions, the provisions of the Commonwealth's 2002 health offerings were more generous than the median of the large employer market and that of other state governments. This differential is expected to increase by 2004, as other employers have indicated that they plan to further increase member cost sharing, while the provisions in the Commonwealth's plans will remain basically the same. However, the Board feels it is important for the Commonwealth to view its health insurance benefits in the context of its total compensation program. In this context, the Board generally believes that the Commonwealth's health benefit plan provisions must be above the median of the market in order to attract and retain qualified employees.

Self Funding

Description

Employee health insurance programs for which the sponsoring employer assumes the financial risk for the cost of medical services received by plan participants (claims) are termed "self-funded" programs. The liability assumed by a self-funded group includes all claims actually paid during a plan year, as well as those claims incurred during the year but not yet paid as of the last day of the plan year.

Under a self-funded arrangement, the risk for claim fluctuations, both positive and negative, would be transferred from the health plans that currently insure the Commonwealth's Public Employee Health Insurance Program to the Commonwealth, except as may be limited through the purchase of some form of stop-loss insurance. Additionally, unless fiduciary responsibility is delegated to a third party administrator (TPA), the Commonwealth would ultimately be responsible for decisions involving claim payments and other administrative determinations associated with the program.

Although it is far more common for indemnity and PPO plans to be self-funded than HMO options, self-funding is *not* limited to indemnity and/or PPO style plans. HMO and POS plans may also be self-funded, particularly for larger groups in health plans where few, if any, services are capitated.

Advantages and Disadvantages

Key advantages and disadvantages of self-funding are outlined below.

Advantages

- When claims are less than projected, the self-funded plan (or the employer) benefits rather than an insurance carrier.
- In the early months of a self-insured arrangement (the terms "self-funded" and "self-insured" may be used interchangeably), claims incurred prior to the effective date of self-funding are paid from the prior insured plan's reserves. This results in an immediate cash flow advantage to the self-insured plan, which should be the source for establishing a reserve for claims incurred but not yet paid.
- In addition to the cost of medical services received by plan participants, both insured and self-funded plans incur administrative expenses for claims payment and other administrative services necessary to operate the plan. However, administrative expenses under a self-funded arrangement are typically lower due to the elimination of insurer risk charges that are normally 2-5% of total premiums. Additionally, assuming that claim reserves are invested by the self-funded plan, the interest earned on these reserves will likely exceed the interest credits, if any, included in the insured plans' rate determinations.

- A higher percentage of prescription drug formulary rebates, usually 2-3% of pharmacy claims or .4% to .6% of total claims, are normally credited to the plan sponsor under a self-funded arrangement than under an insured arrangement.
- A self-funded program may have more negotiation flexibility with providers. Through direct contracting, a self-funded program may be able to include more providers in the plan's network, albeit at a higher cost to the plan.
- A self-funded program typically has more design flexibility. For example, a self-funded employer can offer options with HMO style benefits in areas where HMOs do not exist. This may result in more consistency in the benefit options offered to plan participants in different geographic areas of the Commonwealth.
- In 2003, the Commonwealth's health insurance risk pool was split among four insurance carriers, segmenting its risks based on plan availability by geographic area and individual employees/retirees' selections. Under a self-funded arrangement, the Commonwealth could consolidate its risk pool and have increased flexibility in allocating its healthcare program's costs. By consolidating its health insurance risk into a single risk pool, the Commonwealth could eliminate regional health insurance option and employee contribution variations. However, this would likely result in fewer health options in some areas and higher employee contributions in some areas than under the current arrangement.
- By self-funding, employers increase their ability to carve out segments of their healthcare program, like pharmacy benefit management, behavioral health services or care/health management to customize the program to meet their specific requirements. Through these carve out arrangements, greater consistency in plan administration, including items like prescription drug formulary changes, may be achieved.

Disadvantages

- The financial risk an employer assumes is the biggest drawback to self-funding. In a self-funded arrangement, if claims and expenses exceed projections, it is the employer that must absorb the deficit. Given the magnitude of the Commonwealth's healthcare program's total expenditures, if claims and expenses exceeded projections by only 5%, a deficit of over $30 million would result. This level of variance or more is possible, particularly in the first year of self-funding due to the number of changes that are likely to occur in:
  - Provider network composition and therefore charges and practice patterns;
  - Provider reimbursement arrangements, if networks change; and
  - Claims and care management, if vendors managing the program change.
- It is essential to establish and maintain adequate claim reserves to properly fund a self-insured plan's obligations. Any pressure to use healthcare program reserves for other purposes must be resisted, if the program is to be financially sound. If reserves reach excessive levels, careful management is required to maintain stability in employee contribution amounts, particularly given that the Commonwealth does not currently explicitly subsidize the cost of dependent healthcare coverage.

- Under a self-funded arrangement, the Commonwealth may not be able to duplicate the current provider networks in place. If this occurs, the relationship between a patient and his/her healthcare provider(s) may be disrupted.
- While self-funding may increase the Commonwealth's flexibility in negotiating with healthcare providers and the options offered to its members, this flexibility could result in increased health plan costs for the Commonwealth and its employees/retirees.
- Insured plans resolve contested or unusual claims and act as a third-party buffer for the employer. Unless the Commonwealth delegates fiduciary responsibility for claim determinations and payments to the third party administrator, under a self-funded arrangement, the Commonwealth would be faced with making these determinations. Claim denials may be directly attributed to the Commonwealth and have the potential for causing increased employee dissatisfaction or increased pressure to pay ineligible expenses, thereby increasing plan expenditures. Additionally, legal actions taken by plan members could include the Commonwealth.

Considerations

In addition to the advantages and disadvantages outlined above, the Commonwealth should consider the following in reaching a decision whether to self-fund its employee healthcare program:

- Actuarial assistance will be required to establish funding rates (pseudo premium rates) that can be expected to cover the claims paid by the health plan and administrative expenses of the plan and to establish adequate reserves for claims incurred but not yet reported or paid by the plan.
- Many self-funded health plans obtain stop-loss coverage to limit their maximum liability. Stop-loss coverage is basically insurance that covers expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). However, given the size of the Commonwealth Group, it is anticipated that the premiums paid for stop-loss coverage would exceed any reimbursements received from the insurance carrier.
- When self-funded, a health plan becomes subject to Internal Revenue Code Section 105(h) non-discrimination rules. Given the current structure of the Commonwealth's Public Employee Health Insurance Program, this should not create a problem. However, this provision would need to be considered, if any revisions to the plan were considered that would discriminate in favor of highly compensated employees as defined by Section 105(h). It also would need to be taken into account, if the Commonwealth becomes involved in decisions as to whether to cover questionable expenses under the plan for highly compensated individuals or their family members.
- Reserves must be established and maintained in a sufficient amount to cover medical services that have been received, for which payments have not yet been made. This requirement is addressed in more detail in the section titled *Funding Requirements* which follows.

- The Commonwealth would need to assume responsibility for new functional requirements. These requirements and associated staffing implications are outlined in the section titled *Staffing Requirements.*

2002 and 2003 Health Insurance Bids

For 2002, the Commonwealth's claims experience and enrollment as reported by MedStat indicates that $17.92 per covered life or $29.08 per employee/retiree (contract) was retained, on average, by the Commonwealth's insurance carriers to cover their operating expenses. This compares to the lowest per contract fixed cost quoted by bidders in response to the Commonwealth's 2002 RFP of $35.00. In essence, had the Commonwealth self-funded its health insurance program in 2002 and paid the same amount to health care providers for the care and supplies provided to members of the Public Health Insurance Program, its costs would have been roughly $10 million more than it experienced under its insured arrangement. This differential could have been higher, if the administrator with which the Commonwealth contracted had higher negotiated rates with health care providers or was less aggressive in managing health care expenses that the carriers with which the Commonwealth insured its program. Additionally, it does not take into account the additional cost to the Commonwealth for the expanded administrative requirements it would assume under a self-funded arrangement.

In the 2003 health insurance Request for Proposal (RFP), the Commonwealth asked bidders to quote both self-funded and insured arrangements. The Commonwealth only received one qualified self-funded statewide bid. This bid was limited to PPO and EPO coverage options.

The 2001 incurred claims for the Public Employee Health Insurance Program, as reported by the Commonwealth's health insurance carriers, were projected forward to 2003 assuming 14% health insurance cost trend per year. Adding the projected 2003 claims to the administrative fees and specific stop-loss premiums quoted by the qualified self-funded bidder, the Commonwealth's 2003 cost was projected to be from 6% to 15% higher than it would be under the final insured bids received for 2003 under the Commonwealth's current structure. This cost differential does not take into account the additional cost to the Commonwealth for the expanded administrative requirements it would assume under a self-funded arrangement. (See the Staffing Requirements section for additional information.)

Funding Requirements

Reserves must be established and maintained in a sufficient amount to cover medical services that have been received, but for which payments have not yet been made. Care must be taken to maintain reserves at an adequate but not excessive level. Based on the experience reported by the Commonwealth's insurance carriers, this reserve would need to be about 18-20% of paid claims or around $120 million for calendar year 2003.

In years when the reserves held exceed needed levels (surplus) or are below the required amount (deficit) careful consideration will be needed in determining how to spend down the surplus or fund the deficit, including how individual entities that participate in the Commonwealth Group will be affected. The rates required to fund claims and expenses for future periods should be developed based on expected future claims and expenses irrespective of reserve deficits or

surpluses. To the extent possible, reserve surpluses and deficits should be addressed independently of future funding rates.

If reserve surpluses are taken into account in establishing funding rates for a period and experience develops as expected, funding rates for the subsequent period would need to be increased by both the surplus taken into account for the current period and expected inflation. If they are not, a deficit will result in the subsequent period. This is similar to the experience of Kentucky Kare in the years following 1993 when policymakers decided to place a moratorium on premium increases until its reserves were reduced.

If reserve deficits are taken into account in establishing funding rates for a period and experience develops as expected, the funding rate increase for the subsequent period would be offset by the deficit recouped in the current period. This may result in sea-sawing medical rates. This is illustrated by the following example:

- Suppose projected costs for 2002 were $500 million based on an aggregate, annual funding rate of $5,000 for 100,000 enrollees. However, actual expenses for 2002 were $600 million, generating a deficit of $100 million or 20%.
- Assuming medical inflation of 10% from 2002 to 2003, the projected composite annual rate, including full deficit recoupment, would be $7,600 for 2003 – $6,600 to fund expenses expected to be incurred in 2003 ($6,000 x 110%) plus $1,000 to fund the deficit ($100 million divided by 100,000 enrollees). In essence, funding rates would have increased 52% from 2002 to 2003.
- If actual expenses for 2003 were $660 million as expected and medical inflation was expected to be 10% from 2003 to 2004, the 2004 composite annual funding rate per enrollee would be $7,260 ($6,600 x 110%), a reduction of about 4.5%.
- If actual expenses in 2004 were $726 million as expected, the composite annual funding rate for 2004 would need to increase by the expected medical trend from 2004 to 2005. If this were 10%, the annual funding rate per enrollee would increase 10%.

Staffing Requirements

Under a self-funded arrangement, the Commonwealth would need to assume responsibility for new functional requirements that are not present today:

- establishing and maintaining a "fund" to hold reserves;
- setting up banking procedures for remittance of administrative expenses and claim payments to the third party administrator(s) the Commonwealth selects to pay its healthcare claims; and
- implementing centralized facility(ies) to determine the "premiums" due each month from each entity participating in the Commonwealth's Public Employee Health Insurance Program, collecting "premiums" from each entity, reconciling premiums received with each entity's eligibility information, remitting monthly payments for administrative expenses and weekly or daily payments for claims to the Commonwealth's third party administrator(s), and reconciling the balance in the reserve fund.

New procedures would need to be established and additional staffing obtained to support these additional functional requirements.

Findings

- Based on the Commonwealth's 2001 survey of other states, the majority of other states (72%) self-fund at least one of their health insurance options. However, only 15% self-fund their entire health insurance program.
- In the past, the Commonwealth's insured funding arrangement has been consistent with other states in view of the heavier concentration of Commonwealth Group members enrolled in HMO and POS options. However, this is changing as more members of the Public Health Insurance Program shift to the PPO options.
  - Seventy-six percent of other states responding to the Commonwealth's 2001 survey insured all of their HMO offerings. Another 12% insured some of their HMO offerings and self-funded other HMO options. Only 12% self-funded all of their HMO offerings.
  - For POS and PPO options, other states were split roughly in half regarding their funding arrangement – insured vs. self-funded.
- The advantages and disadvantages of self-funding are outlined in Exhibit XXI.

Exhibit XXI

Self-Funding Advantages and Disadvantages	
Advantages	**Disadvantages**
▪ Lower expected administrative costs ▪ Larger formulary rebate credits ▪ Negotiation flexibility ▪ Design flexibility ▪ Cost allocation flexibility ▪ Customization ability ▪ Potential for increased consistency	▪ Risk assumption – deficit potential ▪ Reserve management ▪ Patient/provider disruption potential ▪ Unavailability of some plan choices ▪ Loss of third party buffer ▪ Impact on Kentucky insurance market ▪ Potentially, increased claim costs due to negotiation/design flexibility ▪ Additional Commonwealth staffing required

Source: Mercer Human Resource Consulting, Inc.

- The 2002 results for the Commonwealth's Public Employee Health Insurance Program indicate that its insured costs were lower than the costs that would have been incurred had the program been self-funded. This assumes that the program's claims costs would have been the same had the program been self-funded. Results of the 2003 health insurance bidding process indicate that the Commonwealth's 2003 health insurance costs would be 6% to 15%

higher, if the Public Employee Health Insurance Program were self-funded rather than insured under its current arrangement.

Conclusions

While the Commonwealth could gain programmatic advantages by self-funding the Public Employee Health Insurance Program, including the potential to offer the same health insurance options, at the same cost, to all its members statewide, there are also several downsides to self-funding.

Although self-funding often has the potential to lower overall health care costs by lowering risk charges and other fixed expenses, in 2002 the Commonwealth's health insurance costs were lower under its insured arrangement than they would have been had the Commonwealth self-funded its program. This assumes that the program's claims costs would have been the same had the program been self-funded.

Results of the 2003 health insurance bidding process indicate that the Commonwealth's 2003 health insurance costs would be 6% to 15% higher, if the Public Employee Health Insurance Program were self-funded rather than insured under its current arrangement. The 2001 incurred claims for the Public Employee Health Insurance Program, as reported by the Commonwealth's health insurance carriers, were projected forward to 2003 assuming 14% health insurance cost trend per year and added to the administrative fees and specific stop-loss premiums quoted by the qualified self-funded bidder to arrive at the program's projected 2003 self-funded cost.

Neither the 2002 nor 2003 cost differential takes into account the additional cost to the Commonwealth for the expanded administrative requirements it would assume under a self-funded arrangement.

Healthcare Flexible Spending Accounts

In calendar 2003, there are about 33,000 active employees who are eligible for coverage under the Public Employee Health Insurance Program, yet waive this coverage. In lieu of health insurance, these individuals receive a monthly contribution of $234 from the Commonwealth into a healthcare flexible spending account (FSA). The Commonwealth's healthcare FSA contribution for 2003 is estimated to be roughly $93 million, before taking into account any forfeitures recouped from individuals who don't utilize all of the funds available. This represents about 15.6% of the Commonwealth's total health insurance expenditures.

As noted in the Market Comparison section of this report, this feature of the Commonwealth's program is much more generous than that of most employers.

- In the Commonwealth's 2001 survey of other states, to which 36 states responded, only 4 (10%) provided an alternative benefit to individuals who waived health insurance. Of these, the alternative benefit ranged from a monthly healthcare FSA contribution of $25 to a maximum of $128 monthly in flex credits.
- In a 2002 survey of large, private sector Kentucky employers, 25% offered an alternative benefit to employees who waived health insurance. For these employers, the alternative benefit ranged from $50 to $75 per month.

If the Commonwealth had reduced its healthcare FSA contribution to those waiving health insurance by 50% to $117 per month, it is estimated that the Commonwealth could have funded about 15% of the dependent portion of health insurance premiums for the lowest cost Option A available in each county. This equates to roughly $54 monthly for those electing Couple coverage, $21 for those electing Parent Plus coverage, and $64 for those electing Family coverage.

Federal Legal Requirements

Sections 105 and 125 of the Internal Revenue Code (IRC) contain specific requirements that healthcare flexible spending accounts (FSAs) must meet in order to qualify for tax-favored treatment for both the member and the employer. Among these requirements are:

- the plan must be in writing and contain certain specified information;
- the plan cannot provide for deferred compensation, other than a profit-sharing, stock bonus or qualified cash or deferred arrangement under IRC sections 401(k)(7) or 401(k)(2);
- the plan cannot discriminate in favor of highly compensated individuals;
- participants may only change their benefit elections during annual enrollment or when they experience certain qualified status changes;
- the maximum amount of reimbursement under a health FSA must be available at all times during the period of coverage (properly reduced for prior reimbursements for the same period of coverage);

- the exclusion of certain medical expenses from eligibility for reimbursement from a healthcare FSA (i.e. long-term care expenses and health insurance premiums);
- claims substantiation; and
- specific rules regarding how FSA forfeitures can be used.

While the Commonwealth has established its flexible benefits program with a legal document and policies designed to comply with the requirements of the Internal Revenue Code, this plan only applies to state employees in the executive branch of the Commonwealth. Other entities, for example, the school boards, have varying programs with provisions that differ from those of the Commonwealth.

Conclusions

Currently, there are inconsistent plans and policies that apply to the funds the Commonwealth contributes for those individuals who are eligible to participate in the Public Employee Health Insurance Program, but who waive health insurance. These inconsistencies can be difficult to explain to employees who believe that they participate in the same "program", and can lead to arrangements that may not comply with IRS laws and regulations.

Program Administration and Governance

Health Insurance Administrative Policies

As indicated in the section titled, Impact of Choice on Commonwealth's Health Insurance Costs, the policies applied by the various entities that participate in the Commonwealth's Public Employee Health Insurance Program can negatively impact the cost of the program. Furthermore, there are specific requirements in Internal Revenue Code laws and regulations that must be met for employee benefits, including pre-tax contributions for health insurance coverage, to maintain their tax-favored status. The Office of Public Employee Health Insurance has adopted a set of rules that fit within the federal government's requirements. While these provisions are incorporated in the contract that new quasi/local governmental agencies must sign if they want to enroll their active employees in the Commonwealth's program, entities whose active employees began participating in the Commonwealth's program prior to November 2002 have not contractually agreed to comply with the Commonwealth's policies nor have the state's retirement systems, making it difficult for the Office of Public Employee Health Insurance to enforce these policies.

On-Site Audits of Insurance Carriers' Performance

To encourage insurance carriers to provide good quality service to Public Employee Health Insurance Program members, OPEHI, and its benefit coordinators, the Commonwealth has incorporated performance guarantees in its health insurance contracts, with monetary penalties if performance standards are not met. OPEHI receives periodic reports from each of the Commonwealth Group's insurance carriers outlining their performance in relation to the performance guarantees to which they agreed and holds meetings and conference calls with the insurance carriers as necessary for continuous quality improvement. However, the Commonwealth's ability to monitor the performance of its insurance carriers and recommend revisions to improve performance over time could be enhanced if on-site performance reviews were conducted by OPEHI, or an independent third party, periodically to verify carriers' reported performance results.

Provider Network Requirements

To attempt to ensure that the health insurance offerings that are made available to members of the Public Employee Health Insurance Program provide adequate access to a reasonable number of healthcare providers at in-network benefit levels, the Commonwealth has specified minimum network requirements in its Request for Proposals for the Public Employee Health Insurance Program. Based on feedback from members of the group and legislators, over time, the Office of Public Employee Health Insurance has modified these requirements (see the October 2002 report for details regarding how these requirements have changed over time). While the health plans providing insurance to the Public Employee Health Insurance Program experience difficulties in keeping their physician provider directories current and there is no accurate, comprehensive database available of all physicians practicing in a given county within the Commonwealth, the

Board feels that it is important for the program to require minimum provider network requirements.

Conclusions

- With no statutory or contractual requirement in place with many of the entities that participate in the Public Employee Health Insurance Program to comply with the Office of Public Health Insurance (OPEHI) administrative rules, it is difficult for OPEHI to enforce consistent policies that protect the financial integrity of the program and ensure compliance with Internal Revenue Code rules and regulations.

- OPEHI receives periodic reports from each of the Commonwealth Group's insurance carriers outlining their performance in relation to the performance guarantees to which they agreed and holds meetings and conference calls with the insurance carriers as necessary for continuous quality improvement. However, the Commonwealth's ability to monitor the performance of its insurance carriers and recommend revisions to improve performance over time could be enhanced if on-site performance reviews were conducted by OPEHI, or an independent third party, periodically to verify carriers' reported performance results.

- While the health plans providing insurance to the Public Employee Health Insurance Program experience difficulties in keeping their physician provider directories current and there is no accurate, comprehensive database available of all physicians practicing in a given county within the Commonwealth, the Board feels that it is important for the program to require minimum provider network requirements to attempt to ensure that the health insurance offerings that are made available to program members provide adequate access to a reasonable number of healthcare providers at in-network benefits levels.

Legislative Mandates

The Department of Insurance provided the summary in Exhibit XXII of twenty-nine mandated health insurance benefits that currently exist in Kentucky's statutes.

Exhibit XXII

Kentucky Mandated Health Insurance Benefits	
Newborn Coverage	KRS 304.17-042, KRS 304.18-032, KRS 304.32-153, and KRS 304.38-199. Coverage for newborn children from the moment of birth, including necessary care and treatment of medically diagnosed inherited metabolic diseases for newborns—KRS 304.17A-139(2)
Inherited Metabolic Disease	KRS 304.17A-139(4). Coverage for amino acid modified preparation and low protein modified food products for treatment of inherited metabolic diseases for conditions listed in KRS 205.560, if prescription drugs are covered. Benefits can be limited to $4,000 per year for low-protein modified foods and $25,000 per year for medical formulas.
Ambulatory Surgical Centers	KRS 304.17-317, KRS 304.18-035, & KRS 304.32-156. Coverage for treatment at ambulatory surgical centers.
Optometrists, osteopaths, physicians, podiatrists, and chiropractors	KRS 304-17-035, KRS 304.18-095, KRS 304.32-157 & KRS 304.38-195. KRS 304.17A-275 requires that coverage be provided for services provided by osteopaths. Osteopaths can also be PCP's. Services of these providers to be covered as described.
Chiropractors	KRS 304.17A-170 & 171. Access to chiropractors in network plans.
Dentists	KRS 304.17-315, KRS 304.18-097, KRS 304.32-157 & KRS 304.38-1937. Services of dentists to be covered as described.
Temporomandibular Joint Disorder	KRS 304.17-319, KRS 304.18-0365, KRS 304.32-1585 & KRS 304.38-1937. Coverage for specific services related to TMJ and associated disorders. Also see Administrative Regulation 806 KAR 17:090.
Screening Mammography	KRS 304.17-316, KRS 304.18-098, KRS 304.32-1591 & KRS 304.38-1935. Screening mammography at specific intervals. KRS 304.17-316(2)(b) requires mammography coverage at any age for a covered person diagnosed with breast cancer.
Breast Cancer	KRS 304.17-3165, KRS 304.17A-135, KRS 304.18-0985, KRS 304.32-1595 & KRS 304.38-1936. Coverage for the treatment of breast cancer, including ABMT.
Breast reconstruction coverage, endometriosis and endometritis	KRS 304.17-3163, KRS 304.18-0983, KRS 304.38-1934, KRS 304.32-1593 & KRS 304.17A-134.
Psychologists and Clinical Social Workers	KRS 304.17-3185, KRS 304.18-0363, KRS 304.32-166 & KRS 304.38-1933. Services of these providers to be covered as described.

Kentucky Mandated Health Insurance Benefits	
Registered nurse first assistant benefits	KRS 304.17A-146. Health benefit plans that cover surgical first assisting benefits or services must provide coverage for a registered nurse first assistant who performs the services within the scope of their license.
Conversion benefits	2002 Ky. Acts, Chapter 351, Section 9. Maximum benefits of at least $500,000 for conversion policies—KRS 304.18-120(1). Minimum benefits—806 KAR 17:260.
Work Related Illness/Injuries	KRS 304.12-250. No contract can exclude coverage solely on the basis that the health condition is work related.
Disabled Children	KRS 304.17-310. Individual health insurance contracts must continue coverage for disabled children beyond the limiting age. Although this statute is applicable only to individual contracts, group carriers commonly use it.
Adopted Children	KRS 304.17-140. Coverage for legally adopted children or children under court-appointed guardianship.
Human Immunodeficiency Virus	KRS 304.12-013(5). No insurer or HMO may exclude or limit coverage for AIDS, etc.
Maternity Coverage	KRS 304.17A-145. Specified length of hospital stay following vaginal/cesarean deliveries.
Cochlear Implants	KRS 304.17A-131. Coverage for cochlear implants.
Autism	KRS 304.17A-143. Coverage for autism, including respite services.
Diabetes	KRS 304.17A-148. Coverage for diabetic services, supplies, and training.
Women's Health	KRS 304.17A-134, KRS 304.17-3163, KRS 304.18-0983, KRS 304.32-1593 & KRS 304.38-1934. Breast reconstruction, endometriosis, endometritis, and bone density testing.
Domestic Violence	KRS 304.17A-155. Claims may not be denied or considered pre-existing on the basis of domestic violence.
Hospice	KRS 304.17A-250(8). Coverage for hospice care equal to Medicare benefits.
Telehealth services	KRS 304.17A-138. (Effective when the plans are issued or renewed after July 15, 2001)
Mental health coverage	KRS 304.17A-661. Large group health benefit plans must cover mental illness the same as physical illness, if they provide mental illness benefits.
Physician assistant benefits	KRS 304.17A-1473. Health Benefit Plans that cover surgical first assisting or intraoperative surgical care services must provide coverage for the services of a physician assistant. (Effective for Health Benefit Plans issued or renewed on or after July 15, 2001.)

Kentucky Mandated Health Insurance Benefits	
Anesthesia and hospital or facility charges	2002 Ky. Acts, Chapter 199. Requires coverage for payment of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems in all health benefit plans that provide coverage for general anesthesia and hospitalization services.
Hearing aids and related services	2002 Ky. Acts, Chapter 106, Section 1(2). Requires coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.

Source: Kentucky Department of Insurance

In addition to the mandated benefits outlined in Exhibit XXII, there are other statutory requirements that affect the Public Employee Health Insurance Program. Exhibit XXIII provides a brief outline of the key provisions of the mandates enacted by the 2000 General Assembly that apply to health insurance programs. The provisions of those bills for which there is no check mark in the column titled "Impacts Commonwealth Plan" were covered by the Commonwealth's Public Employee Health Insurance Program prior to the enactment of the mandate.

Exhibit XXIII

	Health Insurance Mandates Enacted by 2000 General Assembly	
	Impacts Commonwealth Plan	Key Provisions
HB 9		Mammography coverage
HB 177		Coverage of telehealth services
HB 202	✓	▪ Newborn coverage from moment of birth ▪ Treatment of inherited metabolic diseases including amino acid preparations and low-protein modified food products
HB 268	✓	Mental Health Parity
HB 281		Coverage of services provided by registered nurse first assistants
HB 390	✓	▪ Utilization review rules ▪ Independent external review
HB 757	✓	▪ Hold harmless and continuity of care upon contract termination ▪ Drug formulary summary required at enrollment ▪ Network access requirements modified ▪ Prudent lay person standard for emergency services
SB 279	✓	Prompt payment of medical claims
SB 335	✓	Coverage of certified surgical assistants

These mandates first applied to the Commonwealth's health insurance program effective January 1, 2001. From the claims experience reported by the Commonwealth's health insurance carriers for 2001, aggregated by MedStat, payments attributable to the Mental Health Parity provisions of

HB 268 added about one-tenth of one percent to the Commonwealth's 2001 Public Employee Health Insurance Program claims. Coverage of amino acid preparations and low-protein modified food products for individuals with inherited metabolic diseases under HB 202 added less than one-tenth of one percent to the Commonwealth's 2001 Public Employee Health Insurance Program costs. While the discernible cost of these mandates was low in 2001, based on available data, significant variation can result from year to year. Additionally, the ability to determine the cost of discrete provisions, such as these, is highly dependent on providers appropriately classifying the expenses and insurance carriers accurately recording the expenses. Therefore, the cost impact can easily be understated.

It is not possible to discern the cost impact the other mandates enacted by the 2000 General Assembly had on the Commonwealth's Public Employee Health Insurance Program.

In addition to the health insurance mandates, Senate Bill 288, enacted by the 2000 General Assembly:

- Created the Kentucky Group Health Insurance Board.
- Required the Personnel Cabinet to develop healthcare data collection and analysis capabilities.
- Stipulated the conditions under which groups may leave the Public Employee Health Insurance Program.
- Revised the definition of "employee" with respect to the Commonwealth's healthcare and flexible spending account benefits.
- Required the Personnel Cabinet to report annually to the General Assembly on the financial stability of the Commonwealth's Public Employee Health Insurance Program.
- Required unused flexible spending account funds to be transferred to the state health insurance plan's appropriation account.
- Required carriers bidding to offer healthcare coverage to members of the Public Employee Health Insurance Program to rate all such members as single entity, except for those retirees whose former employers insure their active employees outside the Public Employee Health Insurance Program.
- Precluded certain individuals who are eligible for participation in the Public Employee Health Insurance Program as a retiree from receiving the state health insurance contribution as an active employee as well.

Additional mandates enacted by the 2001, 2002, and 2003 General Assemblies affect the Commonwealth's Public Employee Health Insurance Program. These are summarized briefly in Exhibit XXIV.

The impact of the mandates enacted by the 2001 General Assembly on the Commonwealth's 2002 Public Employee Health Insurance Program's costs is not discernible.

As the mandates enacted by the 2002 General Assembly first impacted the Commonwealth's program on or after January 1, 2003, definitive information on their impact on the program is not

yet available. However, based on enrollment through August 2003, it is estimated that the contiguous county provision attached to House Bill 846 and House Bill 821 will increase the Commonwealth's 2003 health insurance cost by about $1.1 million above what it would have been.

As the mandates enacted by the 2003 General Assembly will first impact the Commonwealth's program on or after January 1, 2004, definitive information on their impact on the program is not yet available.

Exhibit XXIV

Legislation Enacted by the 2001, 2002, and 2003 General Assemblies that Impacts the Public Employee Health Insurance Program

Year Enacted	Bill	Key Provisions
2001	HB 97	The Office of Public Employee Health Insurance was established under the Personnel Cabinet.
2001	HB 138	Coverage of physician assistants assisting in surgery.
2001	HB 145	Personnel Cabinet and Cabinet for Families and Children to prepare recommendations regarding allowing foster parents to participate in the Public Employee Health Insurance Program.
2002	HB 39	Coverage of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems.
2002	HB 163	Expands Kentucky Group Health Insurance Board to include: ▪ The Director of the Administrative Office of the Courts ▪ KRS retiree ▪ KTRS retiree ▪ Active teacher ▪ Active state employee ▪ Active classified education support employee
2002	HB 369	Mail order prescription drug coverage for Public Employee Health Insurance Program.
2002	HB 395	Revised caps for inherited metabolic diseases to be $4,000 annually for low-protein modified foods and $25,000 annually for medical formulas.
2002	HB 801	Entities that join the Kentucky Retirement System must join the Public Employee Health Insurance Program for their active employees.
2002	HB 821	▪ Personnel Cabinet to study whether to allow health insurance bidders to bid different rates in different geographic areas of the Commonwealth. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state contribution for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.

Legislation Enacted by the 2001, 2002, and 2003 General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	**Bill**	**Key Provisions**
2002	HB 846	▪ Restricts individuals to one state contribution for health insurance. ▪ Entities participating in the Public Employee Health Insurance Program must sign a contract with the Personnel Cabinet. ▪ Expands the Advisory Committee of State Health Insurance Subscribers to include 2 members from the Kentucky Association of Counties and 2 from the Kentucky League of Cities. ▪ Directs the LRC to study the cost to members of the state health insurance group as a result of entities covering their retirees under the Public Employee Health Insurance Program but not their active employees and recommend administrative procedures to collect this cost from these entities. ▪ Directs the LRC to study the Public Employee Health Insurance Program. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state contribution for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.
2002	SB 152	Coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.
2002	SCR 34	Directs the Interim Joint Committee on Banking and Insurance to study the feasibility of self-funding at least one health insurance option for state employees.
2003	HB 95	Removes the requirement that an employee's employment must be in the same county as his residence for the employee to be eligible to elect coverage in an adjacent county and receive the state contribution for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does.
2003	HB 183	Requires that the sponsor of a bill that contains a mandated health benefit request, have prepared, and attach a financial impact statement before final consideration by a standing committee.
2003	HB 370	Required the Commonwealth's Public Employee Health Insurance Program to include a scenario that allows regional rating in its 2004 health insurance Request for Proposal, with regions defined as the partnership regions designated by the Department for Medicaid Services.
2003	HB 430	For individuals hired on or after July 1, 2003, increased the service required of participants in SPRS, CERS or KERS from a minimum of 5 years to 10 years to be eligible to participate in the Commonwealth's retiree health insurance program.

Conclusions

There are a significant number of legislative mandates that apply to the Commonwealth's Public Employee Health Insurance Program. While the impact of many of these mandates on the program's costs is difficult to discern, estimates of the impact of a few are provided below:

- From the claims experience reported by the Commonwealth's health insurance carriers for 2001, aggregated by MedStat, payments attributable to the Mental Health Parity provisions of HB 268 added about one-tenth of one percent to the Commonwealth's 2001 Public Employee Health Insurance Program claims.
- Coverage of amino acid preparations and low-protein modified food products for individuals with inherited metabolic diseases under HB 202 added less than one-tenth of one percent to the Commonwealth's 2001 Public Employee Health Insurance Program costs.
- It is estimated that the contiguous county provision attached to House Bill 846, enacted by the 2002 General Assembly, will increase the Commonwealth's 2003 health insurance funding by about $1.1 million.

While the discernible cost of some mandates may be low in a given year, significant variation can result from year to year. Additionally, the ability to determine the cost of discrete provisions is highly dependent on providers appropriately classifying the expenses and insurance carriers accurately recording the expenses. Therefore, the cost impact can easily be understated.

Conclusions

This section provides a consolidated summary of the conclusions presented in the previous sections of this report. The Board's recommendations, based on these findings, are outlined in the Executive Summary. After presenting some general observations about the future of the program and the impact of legislative mandates on the program, the remaining findings are organized in the three categories in which the Board's recommendations are presented: health benefit provisions, program governance and program administration.

General Observations about the Future of the Public Employee Health Insurance Program

- Based on its historical experience and increasing percentage composition of retirees, the Commonwealth's health insurance costs are expected to continue to increase at levels well in excess of general inflation for the foreseeable future.

- As typically occurs, when offered a choice of health insurance options, in general, members of the Commonwealth's Public Employee Health Insurance Program have selected the healthcare options that minimize their total out-of-pocket cost. To date, the selection of HMO A and POS A by members with higher average healthcare expenses has helped lower the Commonwealth's cost, since the Commonwealth funds the lowest cost A option available in each county, which, for the most part, has been the PPO A option. However, as enrollment migrates to the PPO A option, as occurred in 2003 due to health insurance premium increases, so will the higher costs of HMO A and POS A members, thereby exacerbating PPO A premium increases and the increase in the Commonwealth's health insurance expenditures.

- There are a significant number of legislative mandates that apply to the Commonwealth's Public Employee Health Insurance Program. While the discernible cost of some mandates may be low in a given year, significant variation can result from year to year. Additionally, the ability to determine the cost of discrete provisions is highly dependent on providers appropriately classifying the expenses and insurance carriers accurately recording the expenses. Therefore, the cost impact can easily be understated.

Health Benefits Provisions

- With the exception of dependent health insurance contributions, the provisions of the Commonwealth's 2002 health offerings were more generous than the median of the large employer market and that of other state governments. This differential is expected to increase by 2004, as other employers have indicated that they plan to further increase member cost sharing, while the provisions in the Commonwealth's plans will remain basically the same.

However, the Board feels it is important for the Commonwealth to view its health insurance benefits in the context of its total compensation program. In this context, the Board generally believes that the Commonwealth's health benefit plan provisions must be above the median of the market in order to attract and retain qualified employees.

- Public Employee Health Insurance program members' 2002 dependent health insurance premium contributions were 2 to 3 times the market average for large, national employers and state government employers. The magnitude of these contributions has contributed to a continual decline in the percentage of Public Employee Health Insurance Program members enrolling their dependents in the Commonwealth's program. Without a change in the Commonwealth's contribution policy – paying the full cost of single coverage for the lowest cost A option available in each county with no subsidy for dependent premiums – it is anticipated that the percentage of Public Employee Health Insurance Program members enrolling their dependents will continue to decline, as it has since 1999.

Program Governance

- The percentage of Public Employee Health Insurance members that retirees and their covered dependents comprise grew from 14.3% in 1999 to 19% by the end of the first quarter of 2003. Due to the impact of age on individuals' health care costs, as illustrated in Exhibit VII, this trend has significant cost implications for the Commonwealth's Public Employee Health Insurance Program. In fact, in 2002, the average allowed expenses (total covered health expenses incurred by members before applying their co-payments) for retirees and their covered dependents were 84% higher than those of active employees and their dependents.

  This impact is exacerbated by the entities whose retirees participate in the Commonwealth's program whose active employees do not – municipalities and other local governmental bodies and regional universities that participate in a state-sponsored retirement plan. As indicated in the Board's October 2002 report and supported by an independent analysis conducted by The Segal Company at the request of the Interim Joint Committee on State Government, these "unescorted" retirees added between $14 and $16 million in excess claims to the Public Employee Health Insurance Program in 2001.

- Members of the Public Employee Health Insurance Program generally select the option available to them that maximizes the benefit they receive (minimizing their total out-of-pocket expenses), thereby increasing the cost of the program. Similarly, if entities are allowed to choose whether to insure their employees under the program or not, a major factor in each entity's decision will be whether it can obtain lower costs by doing so. Unfortunately, since health insurance premiums are based on the health insurance claims of the group being covered, generally, if an entity's cost would be lower under the Commonwealth's program, the average health care expenses of the entity's members will be higher than the average health expenses of Commonwealth group members overall. This premise is supported by the fact that the 2002 average allowed charges of members of the Public Employee Health Insurance Program employed by quasi/local governmental bodies were 8% higher than the average for all other active employees. Therefore, to the extent possible, it is important for the Public Employee Health Insurance Program to limit, or eliminate, the ability for entities to enter or exit the program or choose just to insure

segments of their employee/retiree population.

- The policies applied by the various entities that participate in the Commonwealth's Public Employee Health Insurance Program can negatively impact the cost of the program. For example, if an entity allows its employees to enroll in or discontinue coverage without restrictions, some employees will only elect coverage when they know they will have expenses, thereby selecting against the plan and increasing the program's costs for all members. Indicative of this type of selection, the 2002 average allowed charges of COBRA beneficiaries were 26% higher than the average for the group overall. Furthermore, there are specific requirements in Internal Revenue Code laws and regulations that must be met for employee benefits, including pre-tax contributions for health insurance coverage, to maintain their tax-favored status.

- Currently, there are inconsistent plans and policies that apply to the funds the Commonwealth contributes for those individuals who are eligible to participate in the Public Employee Health Insurance Program, but who waive health insurance. These inconsistencies can be difficult to explain to employees who believe that they participate in the same "program", and can lead to arrangements that may not comply with IRS laws and regulations.

- With no statutory or contractual requirement in place with many of the entities that participate in the Public Employee Health Insurance Program to comply with the Office of Public Health Insurance (OPEHI) administrative rules, it is difficult for OPEHI to enforce consistent policies that protect the financial integrity of the program and ensure compliance with Internal Revenue Code rules and regulations.

Program Administration

- While the Commonwealth could gain programmatic advantages by self-funding the Public Employee Health Insurance Program, including the potential to offer the same health insurance options, at the same cost, to all its members statewide, there are also several downsides to self-funding. Although self-funding often has the potential to lower overall health care costs by lowering risk charges and other fixed expenses, in 2002 the Commonwealth's health insurance costs were lower under its insured arrangement than they would have been had the Commonwealth self-funded its program. This assumes that the Commonwealth's claims costs would have been the same had the Commonwealth been self-funded. Results of the 2003 health insurance bidding process indicate that the Commonwealth's 2003 health insurance costs would be 6% to 15% higher, if the Public Employee Health Insurance Program were self-funded rather than insured under its current arrangement. The 2001 incurred claims for the Public Employee Health Insurance Program, as reported by the Commonwealth's health insurance carriers, were projected forward to 2003 assuming 14% health insurance cost trend per year and added to the administrative fees and specific stop-loss premiums quoted by the qualified self-funded bidder to arrive at the program's projected 2003 self-funded cost. Neither the 2002 nor 2003 cost differential takes into account the additional cost to the Commonwealth for the expanded administrative requirements it would assume under a self-funded arrangement.

- Some state governments and some private employers have formed cooperatives for the purpose of purchasing prescription drugs, to obtain better pricing arrangements as well as enhanced utilization management services. Participation in a pharmacy benefit purchasing cooperative could lower the Commonwealth's prescription drug costs by 3% to 10% and provide more consistent pharmacy benefit administration (formularies, step-therapy, quantity limits, etc.) to members of the Public Employee Health Insurance Program. However, from a practical perspective, participation in a pharmacy benefit purchasing cooperative will only be an option for the Commonwealth if it decides to self-fund its health insurance benefits at some point in the future.

- To encourage insurance carriers to provide good quality service to Public Employee Health Insurance Program members, OPEHI, and its benefit coordinators, the Commonwealth has incorporated performance guarantees in its health insurance contracts, with monetary penalties if performance standards are not met. OPEHI receives periodic reports from each of the Commonwealth's health insurance carriers outlining their performance in relation to the performance guarantees to which they agreed and holds meetings and conference calls with the insurance carriers, as necessary, for continuous quality improvement. However, the Commonwealth's ability to monitor the performance of its insurance carriers and recommend revisions to improve performance over time could be enhanced if on-site performance reviews were conducted by OPEHI, or an independent third party, periodically to verify carriers' reported performance results.

- To attempt to ensure that the health insurance offerings that are made available to members of the Public Employee Health Insurance Program provide adequate access to a reasonable number of healthcare providers at in-network benefit levels, the Commonwealth has specified minimum network requirements in its Request for Proposals for the Public Employee Health Insurance Program. Based on feedback from members of the group and legislators, over time, the Office of Public Employee Health Insurance has modified these requirements. While the health plans providing insurance to the Public Employee Health Insurance Program experience difficulties in keeping their physician provider directories current and there is no accurate, comprehensive database available of all physicians practicing in a given county within the Commonwealth, the Board feels that it is important for the program to continue to specify minimum provider network requirements.

Glossary

Allowed Charge – The amount paid in total to a healthcare provider for services received by a health plan member. This amount includes both the health plan's payment and the member's cost sharing (deductible, co-payment, co-insurance, etc.). This is the total amount billed by a healthcare provider for a covered service, after the application of the health plan's negotiated discount, but prior to any member cost-sharing.

Brand Name Drug – A trademarked drug for which the manufacturer holds the patent or has purchased the rights to manufacture from the patent holder. Brand name drugs are generally more expensive than generics. A single-source brand name drug is a drug that is only produced by one manufacturer and for which a generic equivalent is not available. Multi-source brand name drugs are drugs produced by more than one manufacturer, as generic equivalents are available.

Capitation – A set amount of money paid to a provider of service based on membership demographics rather than payment based on services provided.

Claim – A billed amount for services or goods obtained from a healthcare provider.

COBRA Beneficiaries - Individuals who no longer meet the eligibility requirements for healthcare coverage through a group health plan, but by federal statute, are eligible to continue their healthcare coverage for a period of time under the employer's healthcare program by paying 102% of the total premium rate.

Co-Payment – A stipulated dollar amount that a health plan member must pay out of pocket when healthcare services, supplies, or prescription drugs are received.

Coinsurance – A percentage of the cost of covered healthcare services, supplies, or prescription drugs that a health plan member must pay out of pocket.

Coverage Tier also referred to as Coverage Level – The choices available to employees with respect to the individuals they wish to cover under an employer's health insurance program. Under the Commonwealth's Public Employee Health Insurance Program, the following tiers (or levels) apply:

- Single – coverage for only the employee or retiree
- Couple – coverage for the employee or retire and his/her spouse
- Parent Plus – coverage for the employee and all eligible children
- Family – coverage for the employee or retiree, his/her spouse and all eligible children

Dependent Subsidy – When an employer specifically pays a portion, or all, of the dependent premium for an employee, this is an *explicit dependent* subsidy. When the differential between single and dependent healthcare premium rates is less than the differential between employee/retiree healthcare claims and dependents' healthcare claims, an *implicit dependent subsidy* exists.

EPO – Exclusive Provider Organization - These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Depending on the insurance carrier chosen, the participant may or may not have to designate a primary care physician to coordinate his/her care. Beginning January 1, 2000, EPO Option C was added to the Commonwealth's Public Employee Health Insurance Program.

Formulary – A preferred list of medications developed by a health plan or Pharmacy Benefit Manager (PBM) to guide physician prescribing and pharmacy dispensing. This list is periodically updated by the PBM to add or remove drugs.

FSA – Flexible Spending Account – A flexible spending account or reimbursement account is funded by employee salary reductions, employer contributions or both. Amounts placed in these accounts are used to provide reimbursement for eligible expenses incurred by the employee or eligible beneficiaries for specified benefits during a plan year.

Fully Insured - also referred to as Insured or Fully Funded - When a health plan assumes the financial risk associated with medical expenses for an employer group in exchange for the premiums paid by the group.

Generic Drug - A drug whose therapeutical ingredients are the same as a brand name drug, but which is sold under a name that is not trademarked. Generic drugs are usually less expensive than their brand name counterpart.

HMO – Health Maintenance Organization - These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Participants in these plans must select a primary care physician to coordinate their care. For the majority of the services covered by the HMO, participants pay a specified dollar amount (co-payment) at the time services are received.

Medical Loss Ratio also referred to as Loss Ratio - The ratio between the incurred claims paid by a health plan and the premium taken in by the health insurer. Example: An insurance company receives $100,000 in premium for a month and pays out $89,000 in claims – the Medical Loss Ratio is 89% ($89,000/$100,000).

Out-of-Pocket Limit – A specified dollar amount present in some health plan provisions that limits the amount of out-of-pocket expenses a plan participant pays in a Plan Year for covered health care services. Once the participant reaches the out-of-pocket limit, the health plan pays 100% of his/her covered healthcare expenses for most or all services.

PBM – Pharmacy Benefit Manager – An organization that functions as a third party administrator for a health plan's pharmacy claims, contracts and management.

POS – Point of Service - These plans mimic the benefits of the HMO options, provided an individual receives services from a healthcare provider that has contracted with the health plan and services are coordinated through the primary care physician designated by the individual. Unlike the HMO options, the POS options provide coverage for services received from a provider that is not in the health plan's network, at a higher cost sharing percentage to the insured.

Preferred Provider Organization (PPO) - These plans require lesser cost sharing from participants, if covered services are received from a healthcare provider that participates in the health plan's network. Coverage is provided for services received from a provider that is not in the health plan's network, with participants paying a larger proportion of the cost of covered services. Unlike POS plans, PPOs do not require referrals from a participant's primary care physician. The PPOs offered under the Commonwealth's Public Employee Health Insurance Program provide the same benefits for services received in a network physician's office and for prescription drugs as do the HMO and POS options. However, for services received in a network hospital or surgical center, PPO participants pay a percentage of the cost of services received (co-insurance) after paying an annual deductible, rather than a specified dollar co-payment. The amount of co-insurance that a participant pays annually is capped by the PPO plan's out-of-pocket limit.

Premium – The monetary amount paid by an employee or the employer for health insurance benefits. Routinely paid on a monthly basis. In an insured program, the amount paid to an insurance company in exchange for its payment of all healthcare costs covered under the terms of the health plan and for administrative services. For large groups, like the Public Employee Health Insurance Program, premiums are determined based on the healthcare services consumed by the plan's members in the past and the prices charged by healthcare providers. If the premiums charged by the insurer are less than the actual healthcare costs incurred by the plan's members and the insurer's operating costs, the insurer loses money. The premium includes both the employer's and employees' contributions for health insurance.

Primary Care Physician – For purposes of the applying the Commonwealth's qualifying network requirements, a primary care physician includes: family practice physicians, general practice physicians, pediatricians, and internists.

Provider Network – A list of contracted health care providers, unique to a health plan, from which an insured can obtain services that are covered under an HMO or are covered at a preferred benefit level under a POS or PPO.

Self Insured – also referred to as Self Funded – A health plan whose medical claims' financial risk is assumed by the employer and not by the health plan.

Specialist Physician – For purposes of the applying the Commonwealth's qualifying network requirements, a specialist physician includes all physicians other than: family practice physicians, general practice physicians, pediatricians, and internists.

Stop Loss Coverage - Stop loss coverage is insurance that covers a health plan's expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). This coverage is also referred to as **Excess Loss Coverage.**

Third Party Administrator (TPA) – An organization that performs health insurance administrative functions (e.g. claims processing) for a plan or an employer. The TPA may also provide the healthcare provider network.

Waiver - An eligible employee or retiree who declines health care coverage through his/her employer for a plan year. Often the employee obtains health care coverage through another means, typically a spouse's employer or an individual.

2002 Commonwealth Group Plan Choices By County

County	HMO	POS	PPO	EPO	Total
Adair	4	4	4	3	15
Allen	2	2	4	2	10
Anderson	6	6	4	3	19
Ballard	2	2	4	2	10
Barren	0	0	4	2	6
Bath	4	4	4	3	15
Bell	4	4	2	2	12
Boone	2	2	4	3	11
Bourbon	6	6	4	3	19
Boyd	0	0	2	1	3
Boyle	4	4	6	3	17
Bracken	4	4	4	3	15
Breathitt	4	4	4	3	15
Breckinridge	2	2	0	1	5
Bullitt	6	6	2	3	17
Butler	2	2	6	3	13
Caldwell	2	2	4	2	10
Calloway	2	2	4	2	10
Campbell	2	2	4	3	11
Carlisle	2	2	4	2	10
Carroll	4	4	2	2	12
Carter	0	0	2	1	3
Casey	4	4	4	3	15
Christian	0	0	2	1	3
Clark	6	6	4	3	19
Clay	4	4	2	2	12
Clinton	2	2	2	2	8
Crittenden	2	2	4	2	10
Cumberland	4	4	4	3	15
Daviess	0	0	2	1	3
Edmonson	2	2	6	3	13
Elliott	0	0	2	1	3
Estill	6	6	4	3	19
Fayette	6	6	4	3	19
Fleming	6	6	4	3	19
Floyd	4	4	4	3	15
Franklin	6	6	4	3	19
Fulton	2	2	4	2	10
Gallatin	2	2	4	3	11
Garrard	4	4	4	2	14
Grant	2	2	4	3	11
Graves	2	2	4	2	10
Grayson	2	2	0	1	5
Green	2	2	6	3	13
Greenup	0	0	2	1	3
Hancock	0	0	2	1	3
Hardin	4	4	2	3	13
Harlan	2	2	2	2	8
Harrison	6	6	2	3	17
Hart	4	4	4	3	15
Henderson	0	0	2	1	3
Henry	6	6	2	3	17
Hickman	2	2	4	2	10
Hopkins	0	0	4	2	6
Jackson	4	4	4	3	15
Jefferson	6	6	2	3	17
Jessamine	6	6	4	3	19
Johnson	4	4	4	3	15
Kenton	2	2	4	3	11
Knott	4	4	2	2	12
Knox	4	4	4	3	15
Larue	4	4	2	3	13
Laurel	4	4	4	3	15
Lawrence	0	0	2	1	3
Lee	4	4	4	3	15
Leslie	4	4	4	3	15
Letcher	2	2	4	3	11
Lewis	2	2	2	2	8
Lincoln	4	4	2	2	12
Livingston	2	2	4	2	10
Logan	2	2	6	3	13
Lyon	2	2	4	2	10
Madison	6	6	4	3	19
Magoffin	4	4	4	3	15
Marion	4	4	6	3	17
Marshall	2	2	4	2	10
Martin	4	4	4	3	15
Mason	2	2	2	2	8
McCracken	2	2	4	2	10
McCreary	4	4	4	3	15
McLean	0	0	2	1	3
Meade	6	6	2	3	17
Menifee	6	6	4	3	19
Mercer	4	4	6	3	17
Metcalfe	2	2	6	3	13
Monroe	2	2	6	3	13
Montgomery	6	6	4	3	19
Morgan	2	2	2	2	8
Muhlenburg	0	0	6	3	9
Nelson	6	6	2	3	17
Nicholas	6	6	4	3	19
Ohio	0	0	6	3	9
Oldham	6	6	2	3	17
Owen	6	6	4	3	19
Owsley	4	4	4	3	15
Pendleton	2	2	4	3	11
Perry	2	2	2	2	8
Pike	4	4	2	2	12
Powell	6	6	4	3	19
Pulaski	2	2	2	2	8
Robertson	4	4	4	3	15
Rockcastle	4	4	2	2	12
Rowan	2	2	4	3	11
Russell	2	2	2	2	8
Scott	6	6	4	3	19
Shelby	6	6	2	3	17
Simpson	2	2	4	2	10
Spencer	6	6	2	3	17
Taylor	0	0	6	3	9
Todd	0	0	2	1	3
Trigg	0	0	2	1	3
Trimble	6	6	2	3	17
Union	0	0	2	1	3
Warren	2	2	6	3	13
Washington	6	6	4	3	19
Wayne	2	2	2	2	8
Webster	0	0	4	2	6
Whitley	4	4	4	3	15
Wolfe	4	4	4	3	15
Woodford	6	6	4	3	19

2003 Commonwealth Group Plan Choices By County

County	HMO	POS	PPO	EPO	Total
Adair	4	4	4	2	14
Allen	2	2	2	1	7
Anderson	4	4	4	2	14
Ballard	2	2	2	1	7
Barren	0	0	2	1	3
Bath	4	4	4	2	14
Bell	4	4	4	2	14
Boone	2	2	4	2	10
Bourbon	6	6	6	3	21
Boyd	0	0	2	1	3
Boyle	2	2	2	1	7
Bracken	2	2	4	2	10
Breathitt	4	4	6	3	17
Breckinridge	2	2	2	1	7
Bullitt	2	2	2	1	7
Butler	2	2	2	1	7
Caldwell	2	2	2	1	7
Calloway	2	2	2	1	7
Campbell	2	2	4	2	10
Carlisle	2	2	2	1	7
Carroll	2	2	2	1	7
Carter	0	0	2	1	3
Casey	4	4	4	2	14
Christian	0	0	4	2	6
Clark	6	6	6	3	21
Clay	4	4	4	2	14
Clinton	2	2	4	2	10
Crittenden	2	2	2	1	7
Cumberland	4	4	6	3	17
Daviess	0	0	2	1	3
Edmonson	2	2	2	1	7
Elliott	0	0	2	1	3
Estill	6	6	6	3	21
Fayette	6	6	6	3	21
Fleming	2	2	2	1	7
Floyd	4	4	4	2	14
Franklin	6	6	6	3	21
Fulton	2	2	2	1	7
Gallatin	2	2	4	2	10
Garrard	4	4	4	2	14
Grant	2	2	4	2	10
Graves	2	2	2	1	7
Grayson	2	2	2	1	7
Green	2	2	2	2	8
Greenup	0	0	2	1	3
Hancock	0	0	2	1	3
Hardin	0	0	2	1	3
Harlan	2	2	4	2	10
Harrison	2	2	2	1	7
Hart	2	2	2	2	8
Henderson	0	0	2	1	3
Henry	4	4	4	2	14
Hickman	2	2	2	1	7
Hopkins	0	0	4	2	6
Jackson	4	4	6	3	17
Jefferson	4	4	2	2	12
Jessamine	6	6	6	3	21
Johnson	4	4	4	2	14
Kenton	2	2	4	2	10
Knott	4	4	4	2	14
Knox	4	4	4	2	14
Larue	0	0	2	1	3
Laurel	4	4	6	3	17
Lawrence	0	0	2	1	3
Lee	4	4	6	3	17
Leslie	4	4	6	3	17
Letcher	2	2	4	2	10
Lewis	2	2	2	1	7
Lincoln	2	2	2	1	7
Livingston	2	2	2	1	7
Logan	2	2	4	2	10
Lyon	2	2	2	1	7
Madison	6	6	6	3	21
Magoffin	4	4	4	2	14
Marion	4	4	4	2	14
Marshall	2	2	2	1	7
Martin	4	4	6	3	17
Mason	2	2	2	1	7
McCracken	2	2	2	1	7
McCreary	4	4	6	3	17
McLean	0	0	2	1	3
Meade	2	2	2	1	7
Menifee	4	4	4	2	14
Mercer	4	4	4	2	14
Metcalfe	2	2	4	2	10
Monroe	2	2	2	1	7
Montgomery	6	6	6	3	21
Morgan	2	2	2	1	7
Muhlenburg	0	0	6	3	9
Nelson	2	2	2	1	7
Nicholas	6	6	6	3	21
Ohio	0	0	4	2	6
Oldham	4	4	4	2	14
Owen	4	4	4	2	14
Owsley	2	2	2	1	7
Pendleton	2	2	4	2	10
Perry	2	2	4	2	10
Pike	4	4	4	2	14
Powell	2	2	2	1	7
Pulaski	2	2	2	1	7
Robertson	4	4	4	2	14
Rockcastle	2	2	2	1	7
Rowan	2	2	4	2	10
Russell	2	2	2	1	7
Scott	4	4	4	2	14
Shelby	2	2	2	1	7
Simpson	2	2	2	1	7
Spencer	2	2	2	1	7
Taylor	0	0	4	2	6
Todd	0	0	4	2	6
Trigg	0	0	2	1	3
Trimble	4	4	4	2	14
Union	0	0	2	1	3
Warren	2	2	4	2	10
Washington	4	4	4	2	14
Wayne	2	2	4	2	10
Webster	0	0	4	2	6
Whitley	4	4	6	3	17
Wolfe	4	4	6	3	17
Woodford	4	4	4	2	14

2002 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person, per plan year; one set of bitewing x-rays per person per plan year.	50% co-insurance; $100 maximum benefit per plan year.	Not covered
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-insurance; $75 maximum benefit per plan year.	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2002 Public Employee Health Insurance Program Benefit Provisions

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins $100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins $75 maximum benefit per year		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness,or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance*	50% co-insurance	50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

2002 Public Employee Health Insurance Program Benefit Provisions

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits and coinsurance amounts for dental, vision, audiometric and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit) $400 maximum benefit per year	40% co-ins*	$20 co-pay (per visit) $300 maximum benefit per year	50% co-ins*
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins* $100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins* $75 maximum benefit per year		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins* Limit 60 visits per year.	40% co-ins*	25% co-ins* Limit 40 visits per year.	50% co-ins*
	Autism Respite Services – $500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-ins*	50% co-ins*	50% co-ins*	50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

2002 Public Employee Health Insurance Program Benefit Provisions

Exclusive Provider Option		Option C
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Coinsurance amounts for autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs	Copay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Respite Services – $500 maximum monthly benefit for children 2 - 21 years of age for respite and rehabilitative care.	50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay

2003 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary	$20 generic $30 brand $60 non-formulary
Dental		Not Covered	Not covered
Vision		Not Covered	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age		
	• Rehabilitative and Therapeutic care	$10 co-pay	$20 co-pay
	• Respite Care	50% co-insurance	50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 40% co-ins* 50% co-insurance*	 $20 co-pay 50% co-insurance	 50% co-ins* 50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit) $400 maximum benefit per year	40% co-ins*	$20 co-pay (per visit) $300 maximum benefit per year	50% co-ins*
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins* Limit 60 visits per year.	40% co-ins*	25% co-ins* Limit 40 visits per year.	50% co-ins*
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-ins*	 40% co-ins* 50% co-ins*	 25% co-ins* 50% co-ins*	 50% co-ins* 50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$50 generic $70 brand $100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $25 co-pay (per visit) 50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay

*Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered.

Referrals and/or prior approval may be required for some services. Please contact your Carrier.